

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1544A

15453

| | | | | | |
|---|-------------------------|--|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Frances Rebecca Alden | | | 2a. DATE OF DEATH Month Day Year Nov. 12, 1968 | | 2b. HOUR 12 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Dec. 16, 1896 | | 6. AGE (In years last birthday) 91 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Westminster | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Baltimore | | | 10. CITY OR TOWN OF DEATH Pikesville | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 6 Waldron Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Pikesville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 6 Waldron Ave. |
| 14. FATHER'S NAME First Middle Last Edwin K. Gernand | | | 15. MOTHER'S MAIDEN NAME First Middle Last Henrietta Parke | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 216-46-0571 | | 17. INFORMANT Miss Alesia Parke Alden, 6 Waldron Ave., Pikesville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) hypertension - sclerotic | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 54 20 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 , 19 68 , to Nov 12 , 19 68 , that (I) (we) last saw the deceased alive on Nov 9 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Palmer F. Williams MD. | | | | 22c. DATE SIGNED Nov 14 68 | |
| 22d. PHYSICIAN'S NAME (Type) PALMER F. WILLIAMS | | | | 22e. ADDRESS BWINGS MILLS - MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 14, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Pikesville Baltimore Md | | | | | |
| 24. FUNERAL DIRECTOR Frank H. Newell Pikesville, Md. | | | | 25a. RECD BY REGISTRAR NOV 19 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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SECRET

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Nov. 15, 1925. Mrs. J. H. Smith

CERTIFICATE OF DEATH

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|--|--|--|--|---|--|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last Altfeld, Goldie, NMI | | | 2a. DATE OF DEATH Month Day Year 11 28 68 | | | 2b. HOUR 2:07 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH XXXXXX | | 6. AGE (In years last birthday) 72 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE, MD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) RANDALLSTOWN Balto. Cnty. General | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 3108B Woodford Pl. | | | | | | | |
| 14. FATHER'S NAME First Middle Last LOUIS | | | 15. MOTHER'S MAIDEN NAME First Middle Last ESTHER SACHS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address MR. JOSHUA ALTFELD, 3108 B WOODFORD PL. #7 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Spring</u> , 19 <u>68</u> , to <u>Nov. 28</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov. 29</u> , 19 <u>68</u> , and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Marvin Goldstein, M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/28/68 | |
| 22d. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN | | 22e. ADDRESS 6001 PARK HEIGHTS AVE. - BALTO, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | 25a. REC'D BY REGISTRAR DATE DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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| <div>15443</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15455</div> | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|-----------------------------------|-----------------------------|--|
| 1. DECEASED-NAME (Type or print) ALEXINE LURAY AMERICA | | | | | | 2a. DATE OF DEATH Nov 23 Day 19 Year 68 | | 2b. HOUR 6:20 M | | | |
| 3. SEX FEMALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH 4/1/24 | | 6. AGE (In years last birthday) 44 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. COUNTY MONTGOMERY | | | 13b. CITY OR TOWN SILVER SPRING | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 1400 FENWICK LANE | | | |
| 14. FATHER'S NAME First THOMAS Middle JACKSON Last SMITH | | | | 15. MOTHER'S MAIDEN NAME First EMMA Middle SMITH Last SMITH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 214-60-4511 | | 17. INFORMANT Address Records, Mt. Wilson State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 563.1 IMMEDIATE CAUSE (a) Gastrointestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Ileostomy DUE TO, OR AS A CONSEQUENCE OF (c) Ulcerative Colitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5722 Primary Tuberculosis, not related to terminal event | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that at (this hospital) attended the deceased from 10/18 , 19 68 , to 11/23 , 19 68 , that at (we) last saw the deceased alive on 23 Nov 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, at (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. Newcomer | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 23 Nov 68 | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-26-68 | | 23c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL CEM. | | 23d. LOCATION (City or Town) (County) (State) SANDY SPRING Montg. MD. | | | | | |
| 24. FUNERAL DIRECTOR George R. Brouder | | | | ADDRESS Rockville | | 25a. REC'D BY REGISTRAR DATE NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

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Information Bureau

Mr. Wilson, Mr. Wilson, Mr. Wilson

Mr. Wilson, Mr. Wilson, Mr. Wilson

Mr. Wilson, Mr. Wilson, Mr. Wilson

Mr. Wilson, Mr. Wilson, Mr. Wilson

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEASED-NAME (Type or print) Seymour Scycle Amos | | | 2a. DATE OF DEATH Month Nov. Day 1 Year 1968 | | | 2b. HOUR 9:20 AM | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH 7-1-89 | | 6. AGE (In years last birthday) 79 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County, Md. | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Boiler Maker | | 12b. KIND OF BUSINESS OR INDUSTRY Industrial | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md. | | 13b. CITY OR TOWN city | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 5N Carey St. | |
| 14. FATHER'S NAME First James Middle Amos Last Amos | | 15. MOTHER'S MAIDEN NAME First Betty Middle Slayden Last Slayden | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO | | 16b. SOCIAL SECURITY NO. 215-24-9467 | | 17. INFORMANT Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO, OR AS A CONSEQUENCE OF (b) 011.9 DUE TO, OR AS A CONSEQUENCE OF (c) 002.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION 002.1 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19 , 19 68 , to 11-1 , 19 68 , that (I) (we) last saw the deceased alive on Nov 1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W. Newcomer | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-1-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | 22e. ADDRESS Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE NOV. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY AMOS FAMILY | | 23d. LOCATION (City or Town) (County) (State) DILLVILLE VA. | |
| 24. FUNERAL DIRECTOR Francis H. Miller | | 25a. REC'D BY REGISTRAR NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div>15445</div> <div> <div>1</div> <div>81-29284</div> </div> <div> <div>85</div> <div>03</div> </div> | | | | | | | | | | | | <div> <div>15457</div> <div>85</div> </div> | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---------------------------|--|--|--|----------------------|--|--|--|
| <div> <div>1</div> <div>85</div> </div> | | | | | | | | | | | | <div> <div>1</div> <div>85</div> </div> | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | First William | | | | Middle Joseph | | | | Last Amrhein | | | | 2a. DATE OF DEATH Month November | | | | Day 9 | | | | Year 1968 | | | | 2b. HOUR P 8:00 M | | | |
| 3. SEX Male | | | | 4. RACE White | | | | 5. DATE OF BIRTH November 8, 1968 | | | | 6. AGE (In years last birthday) YRS. | | | | IF UNDER 1 YEAR MONTHS | | | | DAYS | | | | IF UNDER 24 HRS. HOURS | | | | MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Baltimore | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. CITY OR TOWN Baltimore | | | | 13c. CITY OR TOWN 21237 Balto. | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER 1724 Weyburn Road | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First William | | | | Middle Nicholas | | | | Last Amrhein | | | | 15. MOTHER'S MAIDEN NAME First Mary | | | | Middle W. Gloria | | | | Last Warfield | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) None | | | | 16b. SOCIAL SECURITY NO. None | | | | 17. INFORMANT Parents | | | | Address Mr. William N. Amrhein | | | | (Same) | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 7769 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Atelectasis</u> 762.0 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11-8</u> , 19 <u>68</u> , to <u>11-9</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>11-9-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Ines Cilliani, M.D. | | | | | | | | | | | | | | | | 22c. DATE SIGNED 11-10-68 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | | | | | | | | | | | | | | | 22e. ADDRESS 7620 York Rd. Baltimore, Md. 21204 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 11/12/68. | | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 12 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

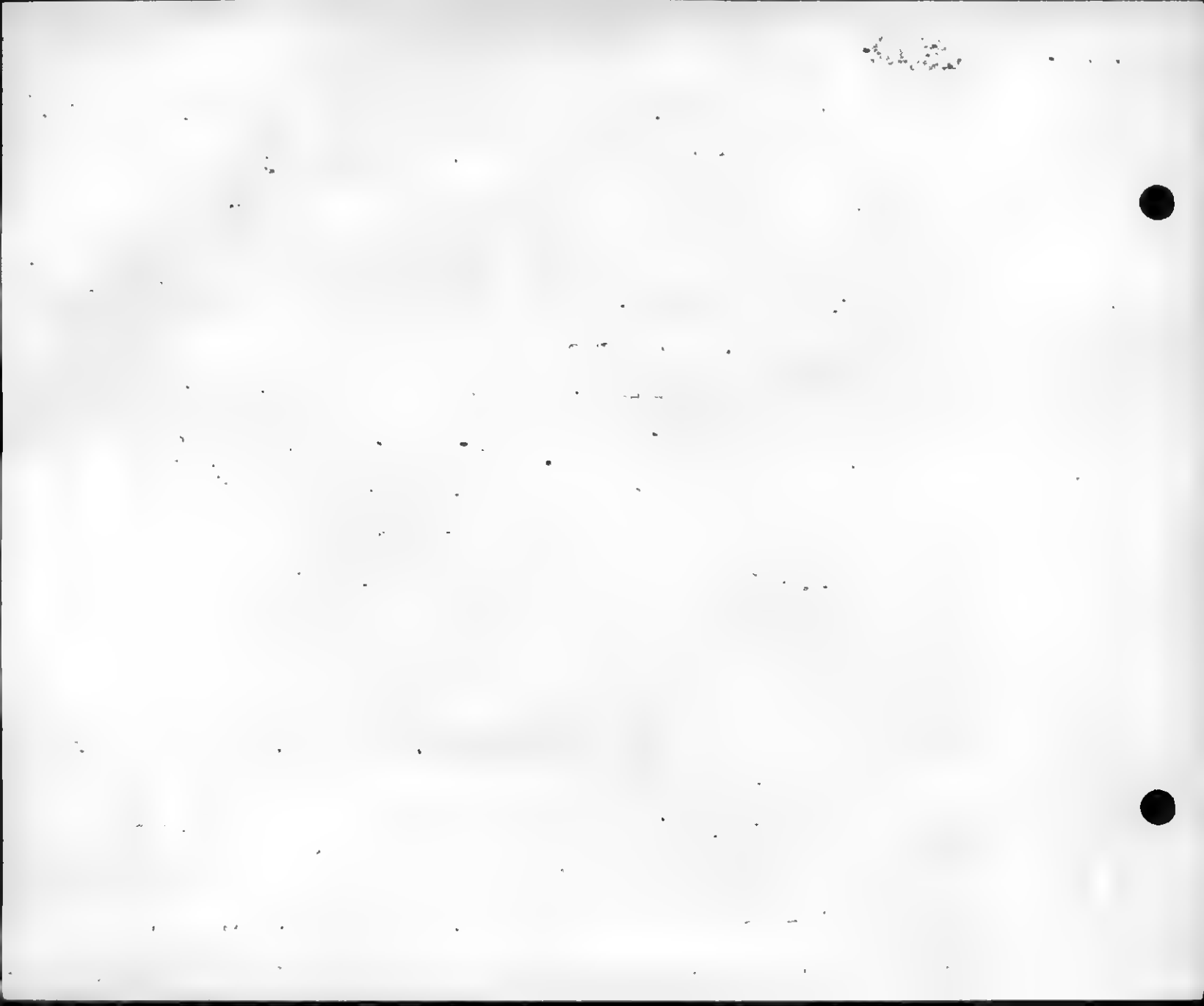
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15446

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15453

| | | | | | | | | |
|--|-----------------------------|---|--|---|------------------------------------|--|--|--|
| 1 DECEASED-NAME (Type or print) | | First | Middle | Last | 2a DATE OF DEATH Month Day Year | | 2b HOUR 2:30 M | |
| Jack | | Elmer | | Anderson | November 8, 1968 | | | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| male | white | | Nov. 26, 1911 | | 56 YRS | | | |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Virginia | U. S. A | | | | Baltimore | | Md. | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | SPRING GROVE STATE HOSP. | | | | transit co. | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Md. | | Pr. Geo. | | Oxon Hill | | | | 10822-Hilltop Drive SE |
| 14 FATHER'S NAME First Middle Last | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| William P. Anderson | | Ella Jane Payne | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | |
| | | 578-10-7151 | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident (CVA)</i> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>possibly hemorrhage</i> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>and arteriosclerosis</i> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus - Obesity</i> | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | |
| 22a I certify that (a) (this hospital) attended the deceased from <i>Sept. 23, 1968</i> , to <i>Nov. 8, 1968</i> , that (b) (we) last saw the deceased alive on <i>Nov. 8, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE <i>Rafael H. Marin</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 11-8-68 | | |
| 22d PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D. | | | | 22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | 11-11-68 | | Cedar Hill Cemetery | | Suitland, Md. | | |
| 24 FUNERAL DIRECTOR <i>Simmons Bros</i> | | | | ADDRESS Wash DC | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> |
| 1661 Good Hope Rd SE | | | | | | NOV 12 1968 | | |

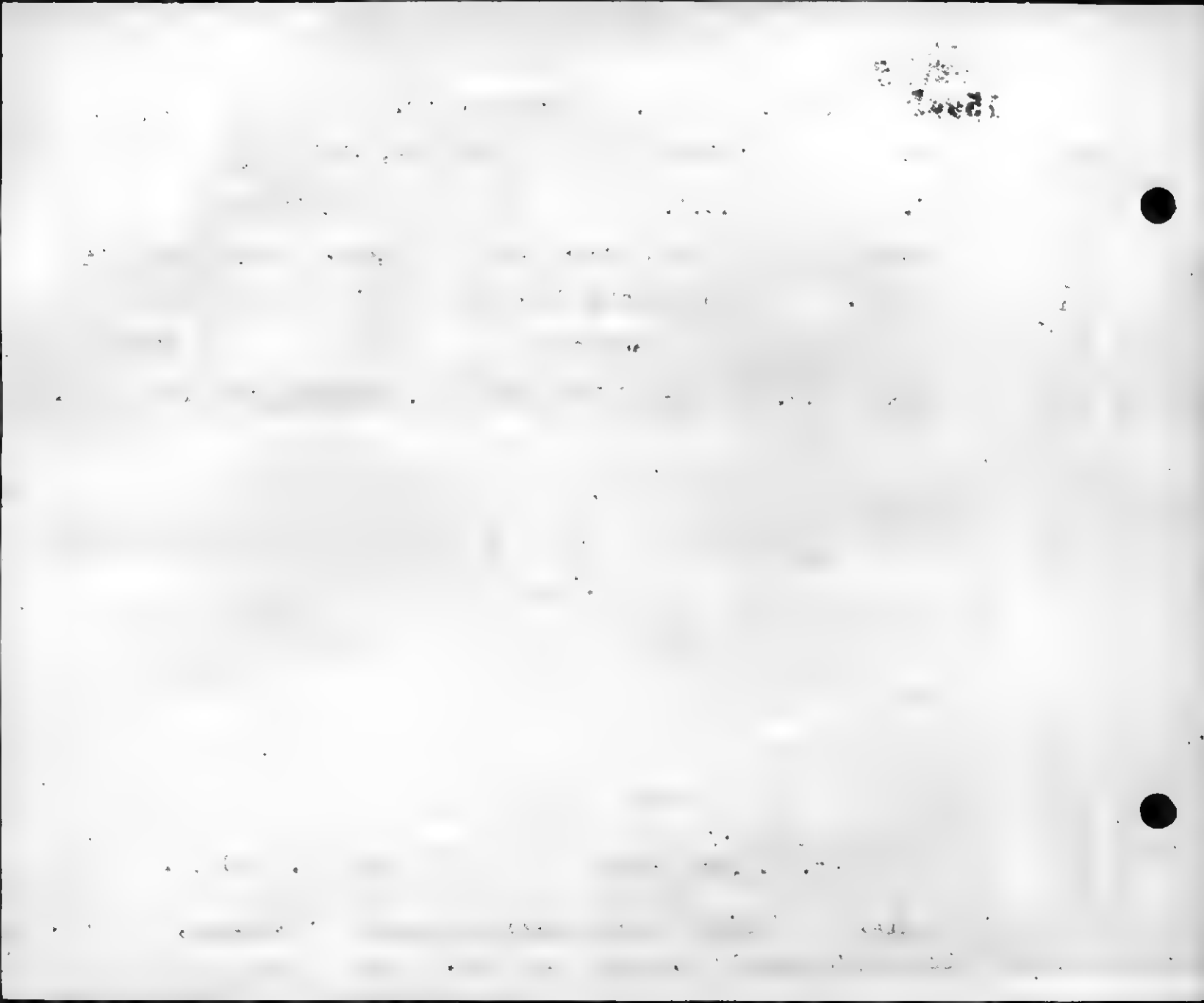


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain remaining papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (11)
30M REV. 1-65

| <div style="display: flex; justify-content: space-between;"> <div> 15447 </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div> <div> 15459 </div> </div> | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|---|----------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First James | | | Middle C. | | | Last Anderson Sr. | | | 2a. DATE OF DEATH Month 11 Day 20 Year 1968 | | | 2b. HOUR M | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH April 24, 1892 | | | 6. AGE (In years lost birthday) 76 YRS. | | | IF UNDER 1 YEAR MONTHS 76 DAYS 76 | | IF UNDER 24 HRS. HOURS 76 M.N. 76 | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6402 Pratt Ave | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Comptroller | | | 12b. KIND OF BUSINESS OR INDUSTRY Oil | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Towson | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 6402 Pratt Ave | | | | | |
| 14. FATHER'S NAME First William Middle Anderson Last Anderson | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Fannon Last Fannon | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) W.W. 1 | | | 16b. SOCIAL SECURITY NO. 109 07 7732 | | | 17. INFORMANT Address Nellie R. Anderson 6402 Pratt Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atrial fibrillation</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Stroke</u> <u>Myocarditis</u> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min | | | |
| | | | | | | | | | | | | | | 10 yrs | | | |
| | | | | | | | | | | | | | | 2 yrs | | | |
| | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> , to <u>Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>CP Coffay</u> | | | DEGREE <u>MD</u> | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED <u>11/22/68</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. E. Paul Coffay | | | 22e. ADDRESS 3100 St. Paul St. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Mitchell Wiedefeld Home | | | ADDRESS 6500 York Rd. | | | 25a. REC'D BY REGISTRAR NOV 25 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | |



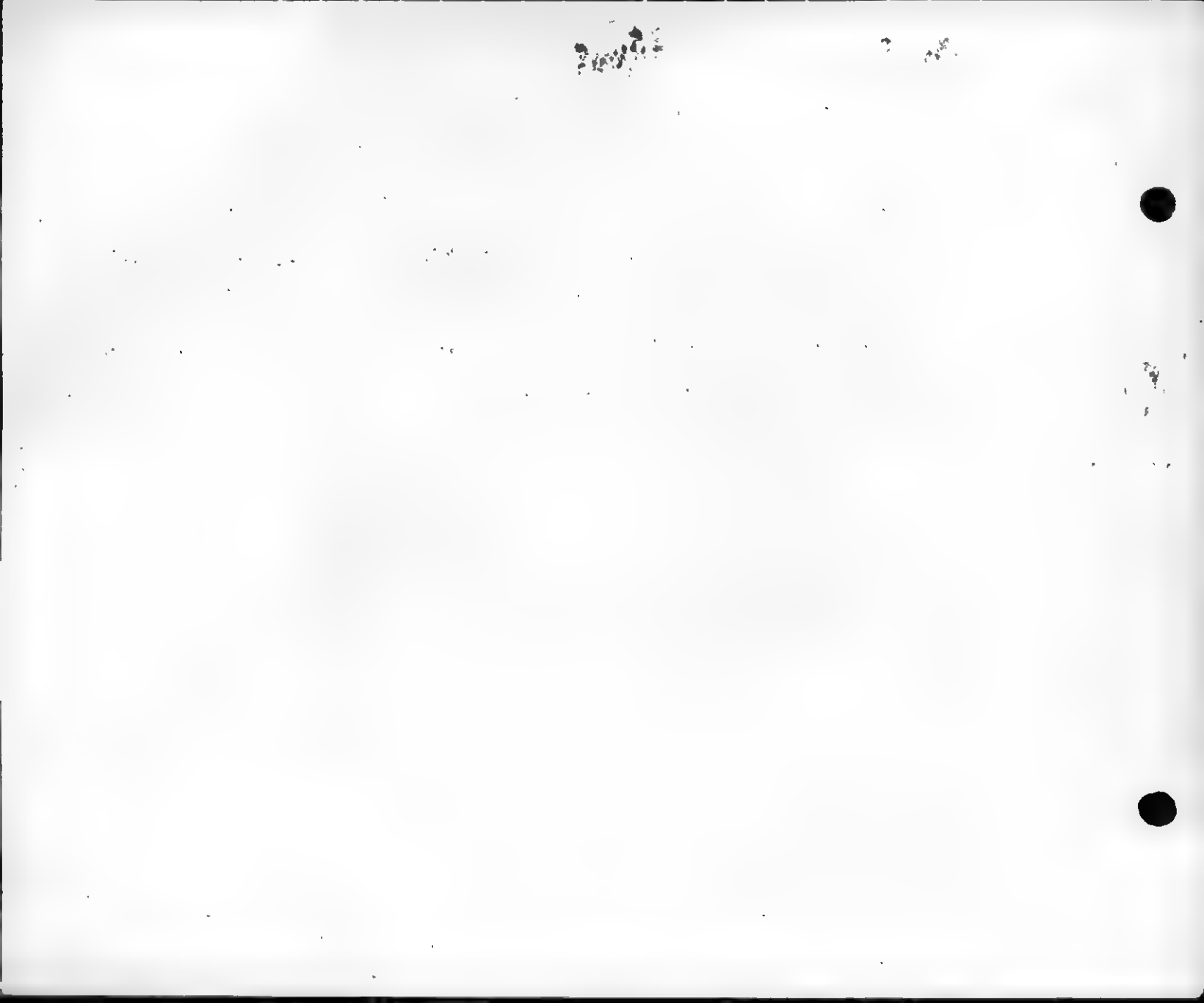
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|--|---|---|---|---|
| 1. DECEASED NAME (Type, or print) 15448 First SISTER Middle MATILDA Last ANGERER | | 2a. DATE OF DEATH Month Nov Day 21 Year 1968 | | 2b. HOUR M |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH AUG. 9, 1886 | 6. AGE (In years last birthday) 82 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) OHIO | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH STEVENSON | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NOTRE DAME INFIRMARY | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TEACHER-RET. | 12b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | 13b. COUNTY BALTO. | 13c. CITY OR TOWN STEVENSON | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER VALLEY RD. |
| 14. FATHER'S NAME First MICHAEL Middle ANGERER Last | | 15. MOTHER'S MAIDEN NAME First MARY LOUISE Middle COLTMANN Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO 220-54-2908 | 17. INFORMANT Address Sister Bernard Marie - Villageville | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4129 (b) 4129 DUE TO, OR AS A CONSEQUENCE OF (c) 4129 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-27-1968 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4721 | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Harold H. B. ... | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22c. DATE SIGNED 11-27-1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 11-23-68 | 23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery | 23d. LOCATION (City or Town) (County) (State) Beltsville Md. | |
| 24. FUNERAL DIRECTOR Galley-Cavanaugh L. H. Cottonville | | 25. REC'D BY REGISTRAR DATE NOV 27 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

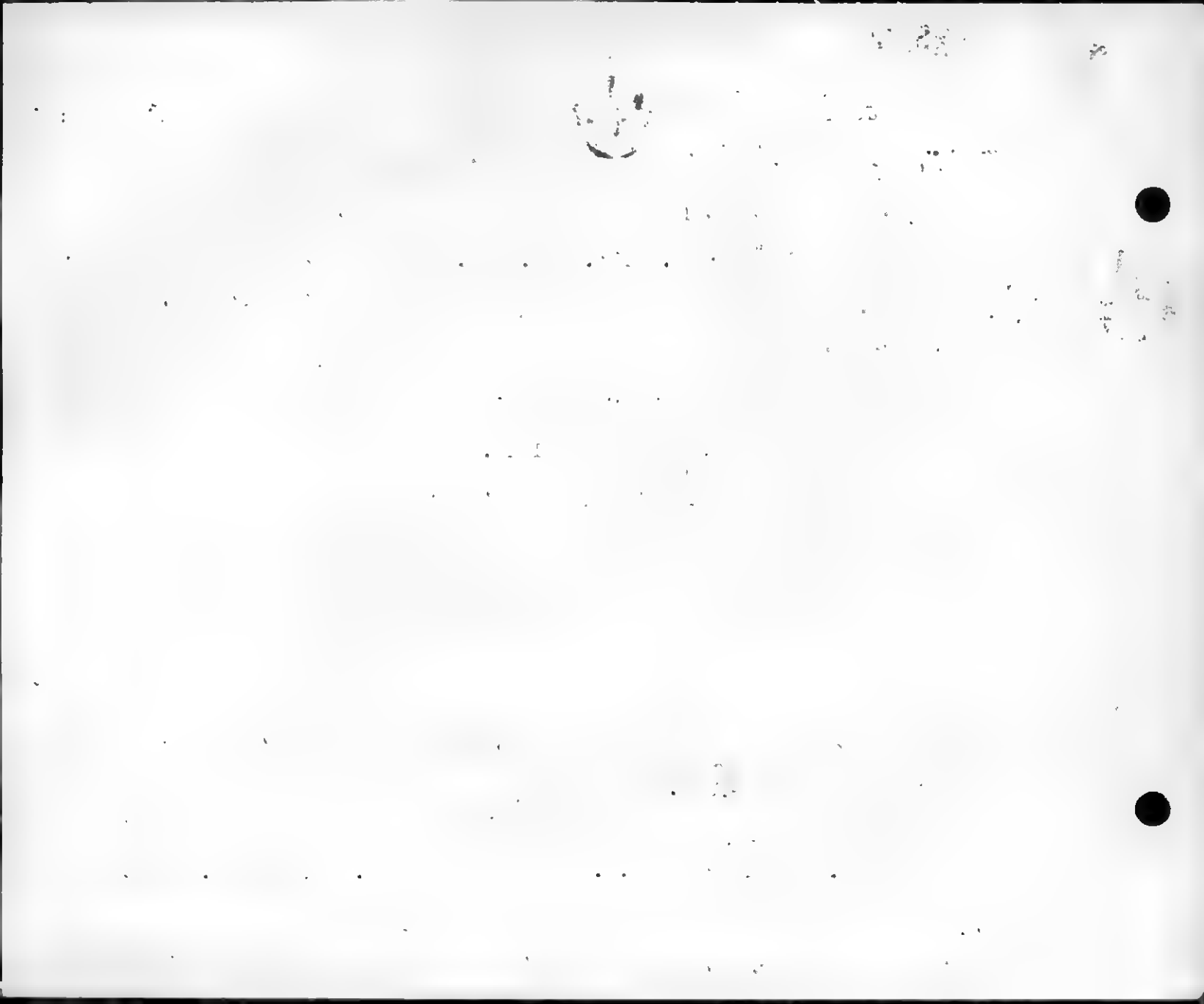


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VR A15 (4)
30M REV 1/68

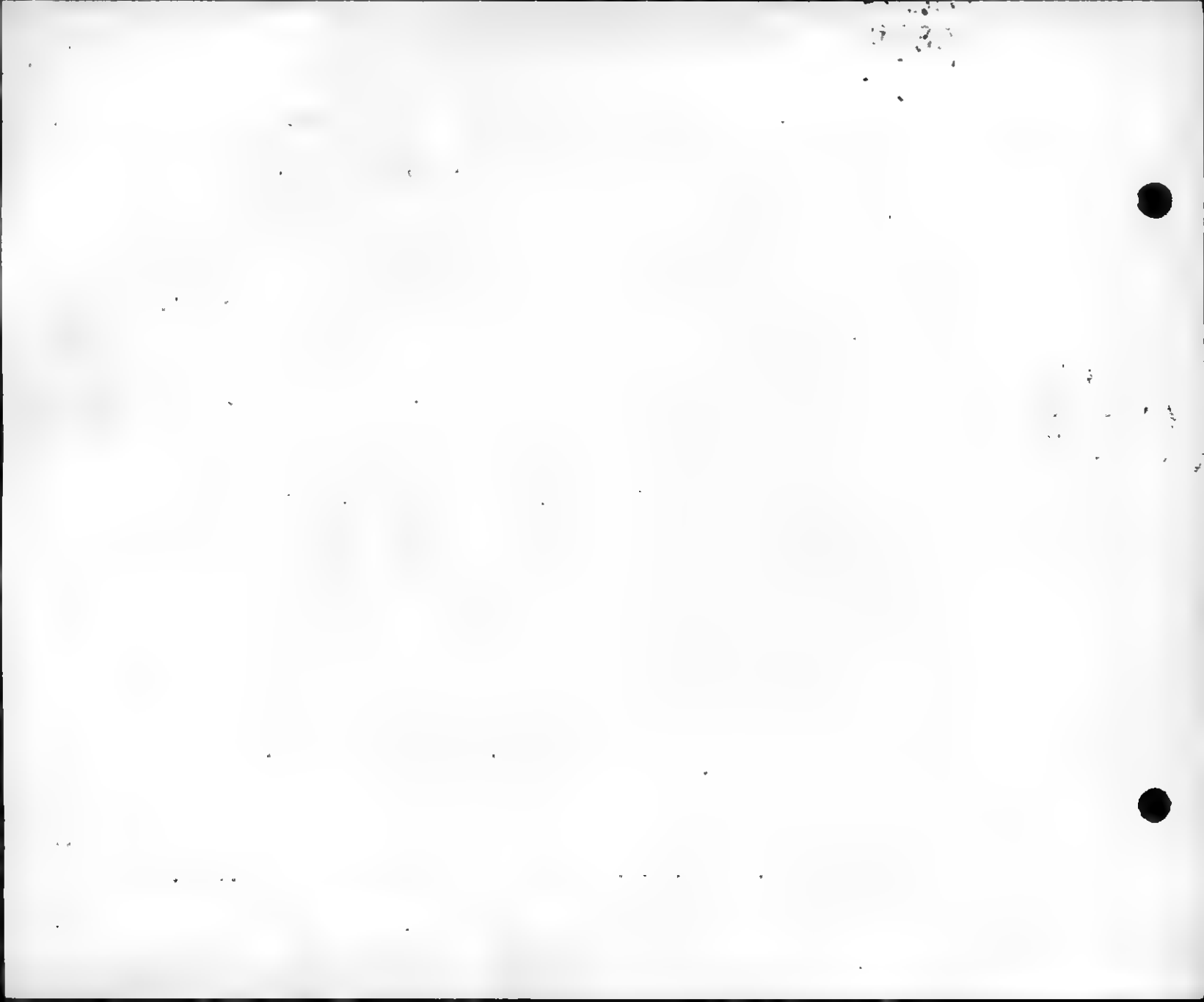
| <div style="display: flex; justify-content: space-between;"> 15449 MARYLAND STATE DEPARTMENT OF HEALTH 15461 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|--|--|---|--|---|
| 1 DECEASED NAME (Type or print) John <i>Arnold</i> | | | | | | 2a. DATE OF DEATH Month 11 Day 24 Year 68 | | | 2b. HOUR 7:28 & MIN AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Aug. 3, 1906 | | | 6. AGE (In years lost birthday) 62 YRS | | IF UNDER 1 YEAR MONTHS 2 DAYS 1 | | IF UNDER 24 HRS HOURS 28 MIN 0 |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore County Md. | | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. Cen. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ins. Foreman | | | 12b. KIND OF BUSINESS OR INDUSTRY Ins. Broker | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 131 Rahmatt Road | | |
| 14. FATHER'S NAME First Charles F. Middle Probst Last Probst | | | | 15. MOTHER'S MAIDEN NAME First Henrietta Middle Diggs Last Diggs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 214-03-2328 | | 17 INFORMANT Address Elizabeth E. Arnold-131 Rahmatt Road | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung. 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis to brain stem DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/10 , 1968, to 11/24 , 1968, that he we saw the deceased alive on Nov. 24 , 1968, and that in (my) (our) our opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE <i>Duncan McGhie</i> | | | | | | 22c. DATE SIGNED 11/24/68 | | | 22d. PHYSICIAN'S NAME (Type) Dr. Duncan McGhie M.D. | | |
| 22e. ADDRESS 6701 N. Charles St. 21204 | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial | | 23d. LOCATION (City or Town) (County) (State) Timonium Md. | | | | | |
| 24 FUNERAL DIRECTOR John C. Miller Inc. - 6715 Selair Rd. - 21205 | | | | | | 25a. REC'D BY REGISTRAR NOV 29 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|----------------------------------|-----------------------------|--|
| <div style="display: flex; justify-content: space-between;"> 15450 15462 </div> <div style="display: flex; justify-content: space-between;"> Item 5 Film G 407 12/6/68 11w CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last Katherine Mary Arnold | | | | | | 2a DATE OF DEATH Month Day Year November 29, 1968 | | | 2b HOUR 1:25 PM | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH 11/16/96 | | 6 AGE (In years lost birthday) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital | | | 12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Homemaker | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Pennsylvania | | | 13b COUNTY Lancaster | | | 13c INS DE CITY & MTS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 340 Beaver St. 17603 | | | |
| 14 FATHER'S NAME First Middle Last Martin Rinier | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Mary Alice Wagner | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address Joseph C. Arnold- Same | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4129 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a I certify that (I) (this hospital) attended the deceased from Nov. 29, 1968 to Nov. 29, 1968 , that (I) (we) last saw the deceased alive on Nov. 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <i>Beatriz P. Dizon</i> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED November 29, 1968 | | | |
| 22d PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D. | | | | | | 22e ADDRESS 7620 York Road Balto., Md. 21204 | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b DATE 12/2/68 | | 23c NAME OF CEMETERY OR CREMATORY Colemanville Meth. | | 23d LOCATION (City or Town) (County) (State) LANCASTER CO. Pa. | | | | | |
| 24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto Md. 21214 | | | | | | 25a REC'D BY REGISTRAR DEC 3 1968 | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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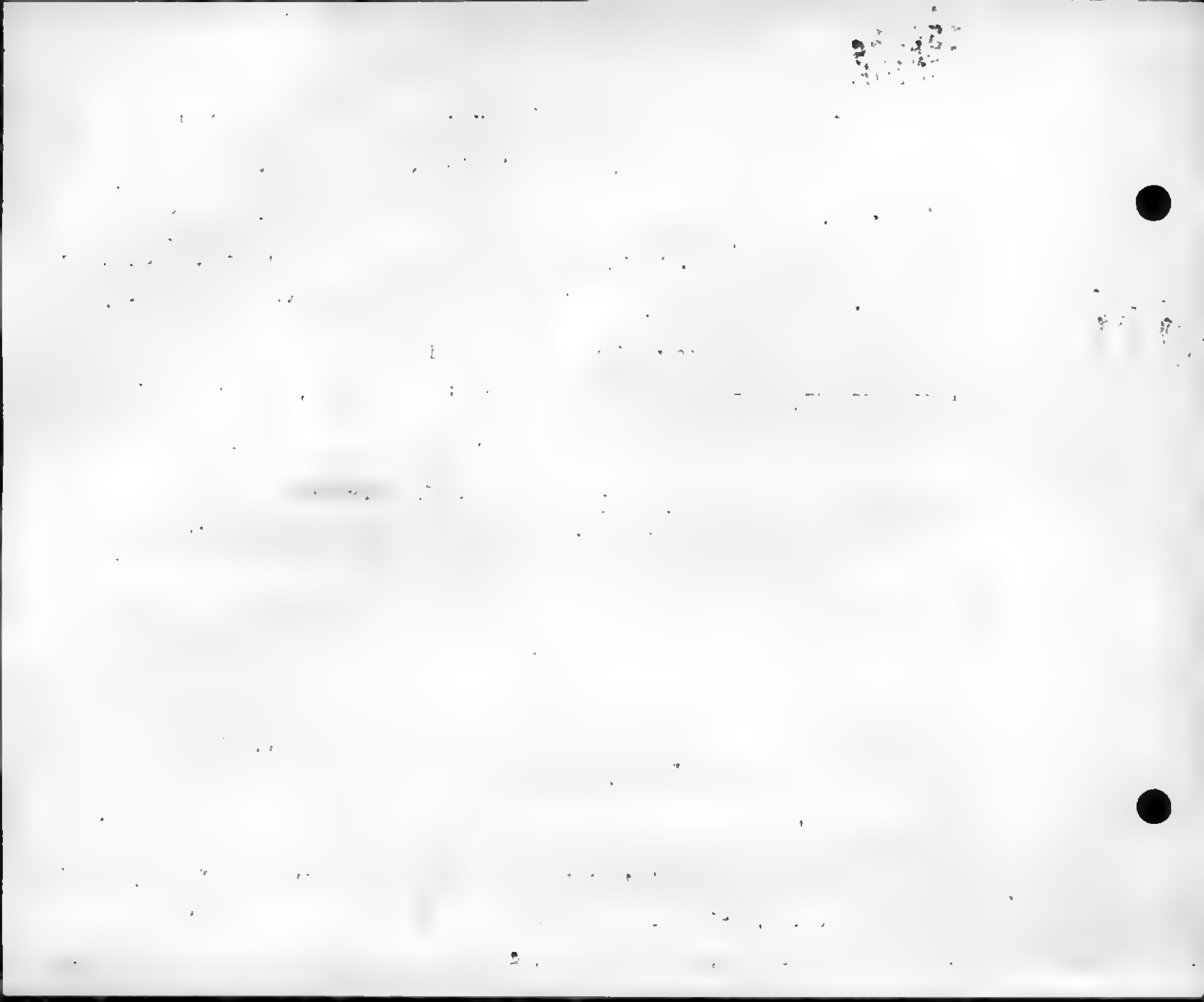
VR 15 (4)
30M REV. 1/68

15452

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15463

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED-NAME (Type or print)* First: ALBERT Middle: FRANKLIN Last: ASCHEMEIER | | | 2a. DATE OF DEATH Month: November Day: 15 Year: 1968 | | 2b. HOUR A 1:20M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH April 26, 1901 | | 6. AGE (In years last birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) New Jersey | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 9220 Satyr Hill Rd. 21234 |
| 14. FATHER'S NAME First: Robert Middle: Last: Aschemeier | | 15. MOTHER'S MAIDEN NAME First: Nellie Middle: Last: Hall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 212-03-6313A | | 17. INFORMANT Helen M. Aschemeier, Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intraabdominal hemorrhage</u> 441.2 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured abdominal saccular aneurysm</u> Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. POSSIBLE CAUSE OF DEATH (c) <u>Oat cell carcinoma of left lung with extensive metastases</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>metastases</u> 451X | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>October 31, 1968</u> , to <u>Nov. 15, 1968</u> , that (X) (we) lost saw the deceased alive on <u>November 15, 1968</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Christine Feliciano</i> | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 11-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) Christine Feliciano, M.D. | | | 22e. ADDRESS 7620 York Road, Towson, Maryland 21204 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Nov. 18, 1968 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd., 21204 | | | 25a. REC'D BY REGISTRAR DATE NO' 18 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Thomas Judge</i> |

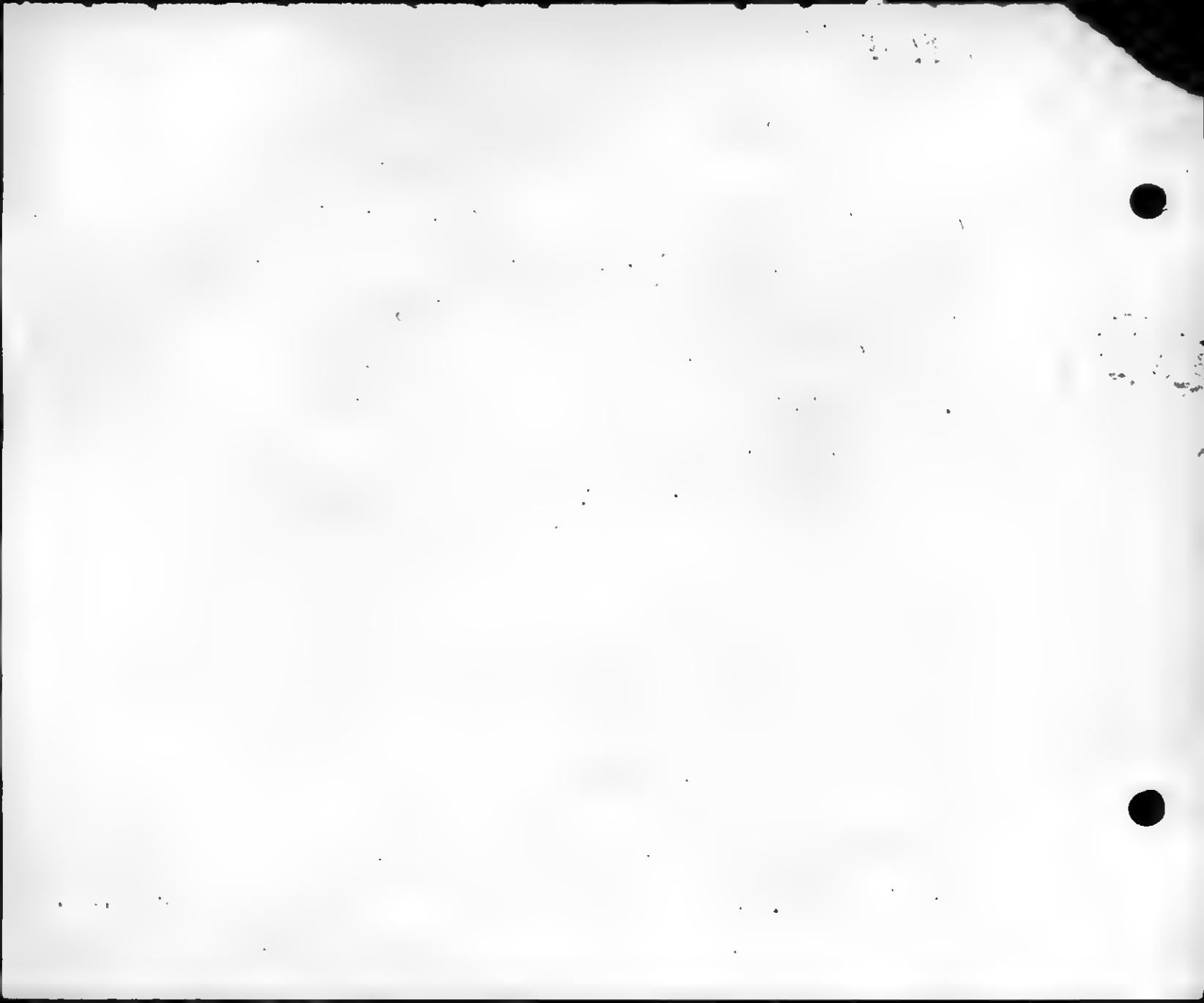


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15458
15458
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> | | c. LENGTH OF STAY IN 1b <u>Timonium</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 Far View Court</u> | | e. STREET ADDRESS <u>103 Far View Court</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Virginia</u> Last <u>Ayres</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1968</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 31, 1898</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Mins. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>A. James Elliott</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Wheeler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Family records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, UNDIFFERENTIATED, METASTATIC</u> <u>1991</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1991</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>Nov 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 6, 1968</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>William A. Pillsbury</u> | | 22b. DATE SIGNED <u>11-8-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William A. Pillsbury</u> | | 22d. ADDRESS <u>Timonium, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 9, 1968</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Shawsville, Harford Co., Md.</u> | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 14 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon back of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

188

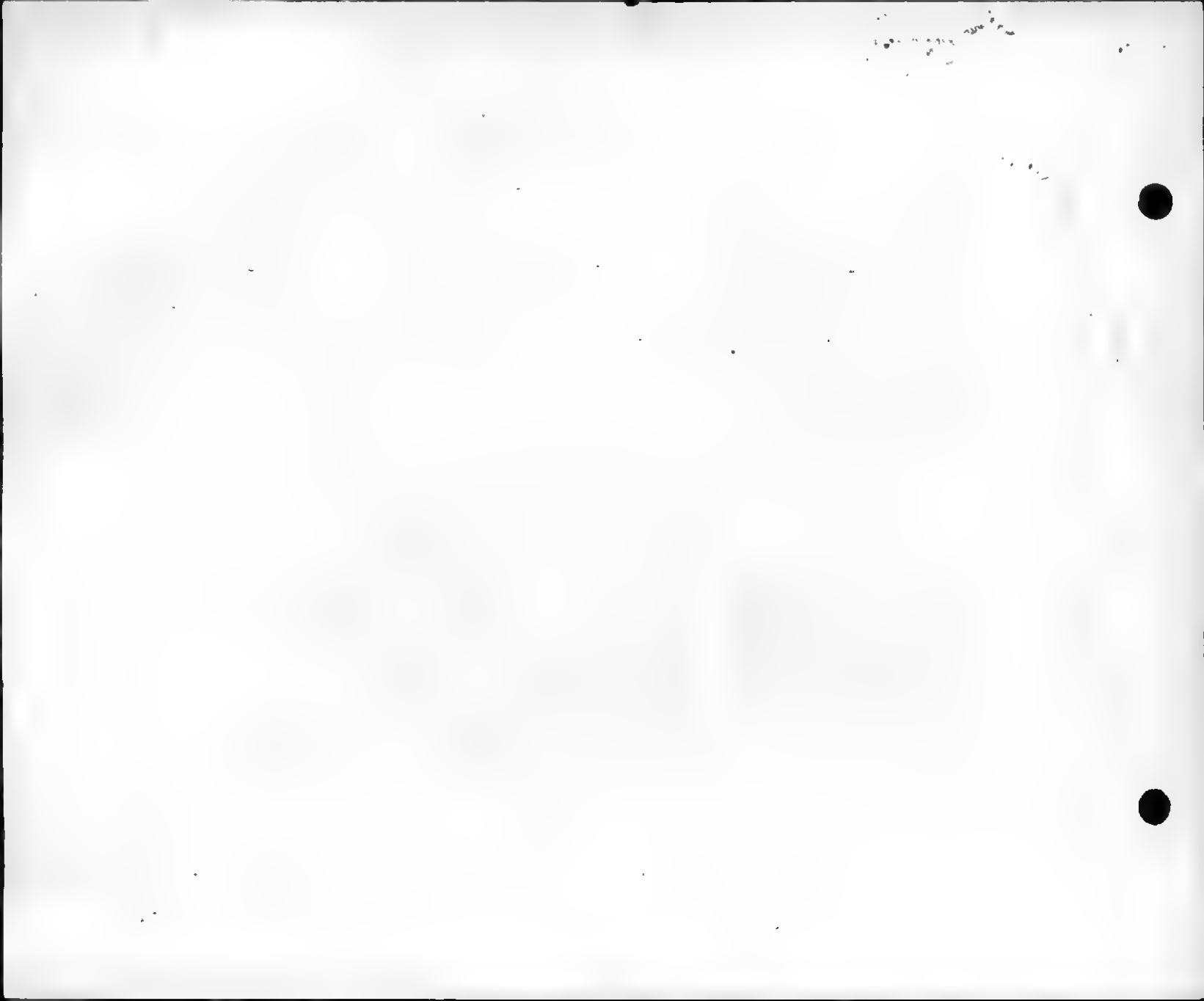
15453

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1546.

CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--|--|--------|---|---|--|----------------------------|---|
| 1 DECEASED NAME (Type or print) Harry | | First | Middle | Last | 2a. DATE OF DEATH Month 11 Day 21 Year 1968 | | 2b. HOUR 6:20 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH August 16, 1885 | | 6. AGE (In years last birthday) 83 YRS | | IF UNDER 1 YEAR MONTHS 83 DAYS 83 HOURS 83 M.N. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, Md | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed | | 12b. KIND OF BUSINESS OR INDUSTRY Florist | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 404 King Ave. & Babikow Rd |
| 14. FATHER'S NAME First William Middle E. Last Babikow | | 15. MOTHER'S MAIDEN NAME First Sophia Middle Becker Last Becker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 212-32-4886 | | 17. INFORMANT Mrs Sadie Babikow Address 404 King Avenue Babikow Rd 21206 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Possible myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a) (b) Congestive heart failure sec. to arteriosclerotic stating the underlying cause heart disease lost. (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or RFD No. City or Town County State | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/4/ , 19 68 , to 11/21/ , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 11/21/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Camilo Z. Tombac | | 22c. DATE SIGNED 11/21/68 | | 22d. PHYSICIAN'S NAME (Type) Camilo Tombac, M.D. | | | | |
| 22e. ADDRESS 7620 York Rd., Towson, Md., 21204 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-23-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md | | |
| 24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road 21236 | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15454

CERTIFICATE OF DEATH

15406

| | | | | | | | | |
|---|--|---|--------------------|---|--|---|---------------------------|---|
| 1 DECEASED NAME (Type or print) | | First JENNIE | Middle - | Last BAER | 2a. DATE OF DEATH Month November Day 5 Year 1968 | | 2b. HOUR 1:30 M | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH May 20 1888 | | 6. AGE (In years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Pikesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Milford Manor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 3305 Olympic Ave |
| 14 FATHER'S NAME First Moses | | Middle Maged | | Last Rebecca | | 15 MOTHER'S MAIDEN NAME First Maged | | Middle Maged |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Judge Aaron A. Baer | | Address 3305 Olympic Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1850 OVARIAN BRONCHOPULMONARY CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12/68 , to 11/5/68 , that (I) (we) lost saw the deceased alive on 11/5/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE GOLOMBEC | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/1/68 | | |
| 22d. PHYSICIAN'S NAME (Type) GOLOMBEC | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY Hebrew Young Men | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md | | |
| 24. FUNERAL DIRECTOR Sylvan S. Lewis & Son Inc | | ADDRESS 9610 Reisterstown Rd | | 25a. REC'D BY REGISTRAR DATE NOV 8 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

1935



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VR A15
45M - 1

15455

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15467

| | | | | | | | | | |
|---|--|---|-------------------------|--|---|--|--|--|------------------------------|
| 1 DECEASED NAME (Type or print) | | First JAMES | Middle R. | Last BAILEY | 2a DATE OF DEATH Month 11 Day 7 Year 68 | | 2b. HOUR 7:30A M | | |
| 3 SEX MALE | | 4. RACE NEGRO | | 5 DATE OF BIRTH 8/1/99 | | 6. AGE (In years lost birthday) 69 YRS | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE COUNTY | | | |
| 10 CITY OR TOWN OF DEATH FORT HOWARD | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER | | 12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND | | 13b COUNTY 17 | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 126 S. SCOTT STREET | |
| 14 FATHER'S NAME | | First JAMES | Middle BAILEY | Last BAILEY | | 15 MOTHER'S M A DEN NAME First NANCY | | Middle Mn: UNKNOWN | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES | | 16b SOCIAL SECURITY NO WW 1 | | 17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ABSCESSSES 4409 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) EMACIATION, MARKED DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS MARKED GENERALIZED | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT OLD OLD | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) INTERNAL HYDROCEPHALUS, CAUSE UNDETERMINED, OLD. BENIGN PROSTATIC HYPERTROPHY | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (if this hospital) attended the deceased from 10/19/68 , 19__ to 11/7/68 , 19__, that (if (we) last saw the deceased alive on 11/7/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Peter N. Juvan</i> | | 22c. DATE SIGNED 11/7/68 | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) PETER N. JUVAN, M. D. | | 22e ADDRESS VAH FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 11/12/68 | | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | |
| 24 FUNERAL DIRECTOR <i>Charles A Rice</i> | | 25a RECD BY REGISTRAR NOV 8 1968 | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|--|---|---|---|---|--------------------------------------|--|----------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) ^{First} Robert ^{Middle} Ledley ^{Last} BAKER | | | | | | 2a. DATE OF DEATH ^{Month} Nov. ^{Day} 7 ^{Year} 1968 | | | 2b. HOUR 1:30 PM | | |
| 3. SEX MALE | | 4. RACE CAU. | | 5. DATE OF BIRTH April 5, 1923 | | | 6. AGE (In years last birthday) 45 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH White Hall | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nelson Ave | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN White Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Nelson Ave. | | |
| 14. FATHER'S NAME ^{First} Harry ^{Middle} Meridette ^{Last} BAKER | | | | | | 15. MOTHER'S MAIDEN NAME ^{First} Myrtle ^{Middle} Viola ^{Last} Ledley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. 215 14 5124 | | 17. INFORMANT Caroline Baker | | | | Address Janean 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CA - CEREBRAL DUE TO, OR AS A CONSEQUENCE OF (b) CA - BRONCHOGENIC DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr 2 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 10/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic ca Lung - Cerebral | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/5, 1968, to 11/7, 1968, that (I) (we) last saw the deceased alive on 11/7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE C. Herbert Mueller Jr MD | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/7/68 | |
| 22d. PHYSICIAN'S NAME (Type) C. HERBERT MOELLER Jr | | | | | | 22e. ADDRESS YORK Rd. PARKTON | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 11-9-68 | | 23c. NAME OF CEMETERY OR CREMATORY Duaneys Valley | | | 23d. LOCATION (City or Town) Cockeysville | | (County) Md. | | (State) |
| 24. FUNERAL DIRECTOR Wm Corb-Barnes, Toran | | | | | | ADDRESS 105 York Rd Baltimore Md 21204 | | 25a. REC'D BY REGISTRAR DATE NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15457

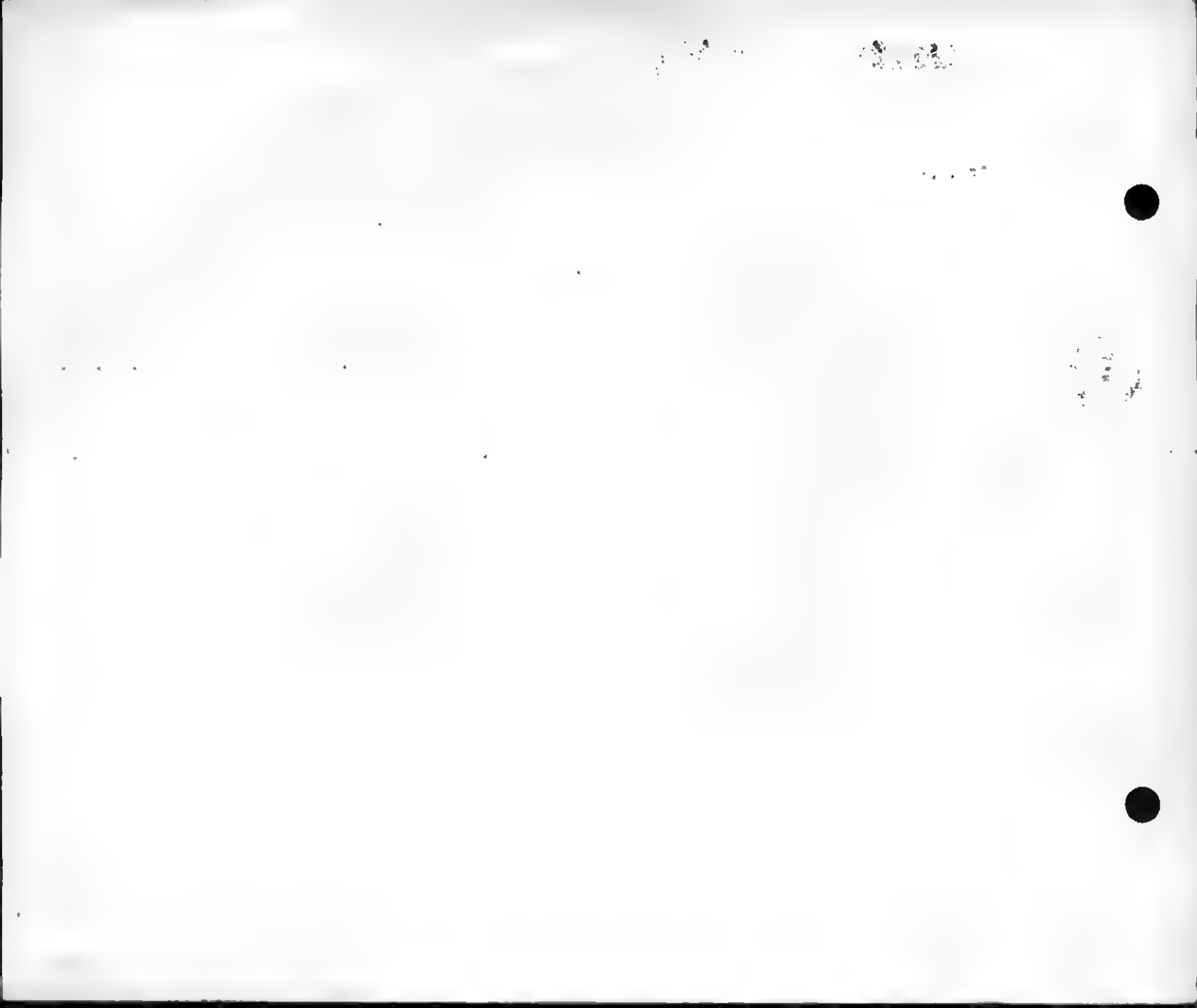
CERTIFICATE OF DEATH

15459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing & Convalescent Home | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Brooklyn Park | |
| 3. NAME OF DECEASED (Type or print) First Edith Middle M. Last Ballantine | | 4. DATE OF DEATH Month November Day 26 Year 1968 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 3, 1882 |
| 9. AGE (In years last birthday) 86 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) Charles Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Walter Miller | | 14. MOTHER'S MAIDEN NAME Jane Carpenter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mrs. Virginia Hancock | | Address 110 W. 14th Ave. 21225 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic - Rt. lower lobe 4579 DUE TO (b) Cerebrovascular accident DUE TO (c) Cerebral Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years 2 6 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 14, 1955 to Nov 26, 1968 , that (I) (we) last saw the deceased alive on Nov 26, 1968 , and that death occurred at 4 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE Benjamin Berdann, M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS 615 Hammonds Lane Balto. Md. 21225 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 11/29/68 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION (City or town) (County) (State) Pikesville, Md. Balto. Co. |
| 24. FUNERAL DIRECTOR McCully F.H. | | 25a. REC'D BY REGISTRAR NOV 29 1968 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



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VR A15
30M REV 1-68

15458

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15458

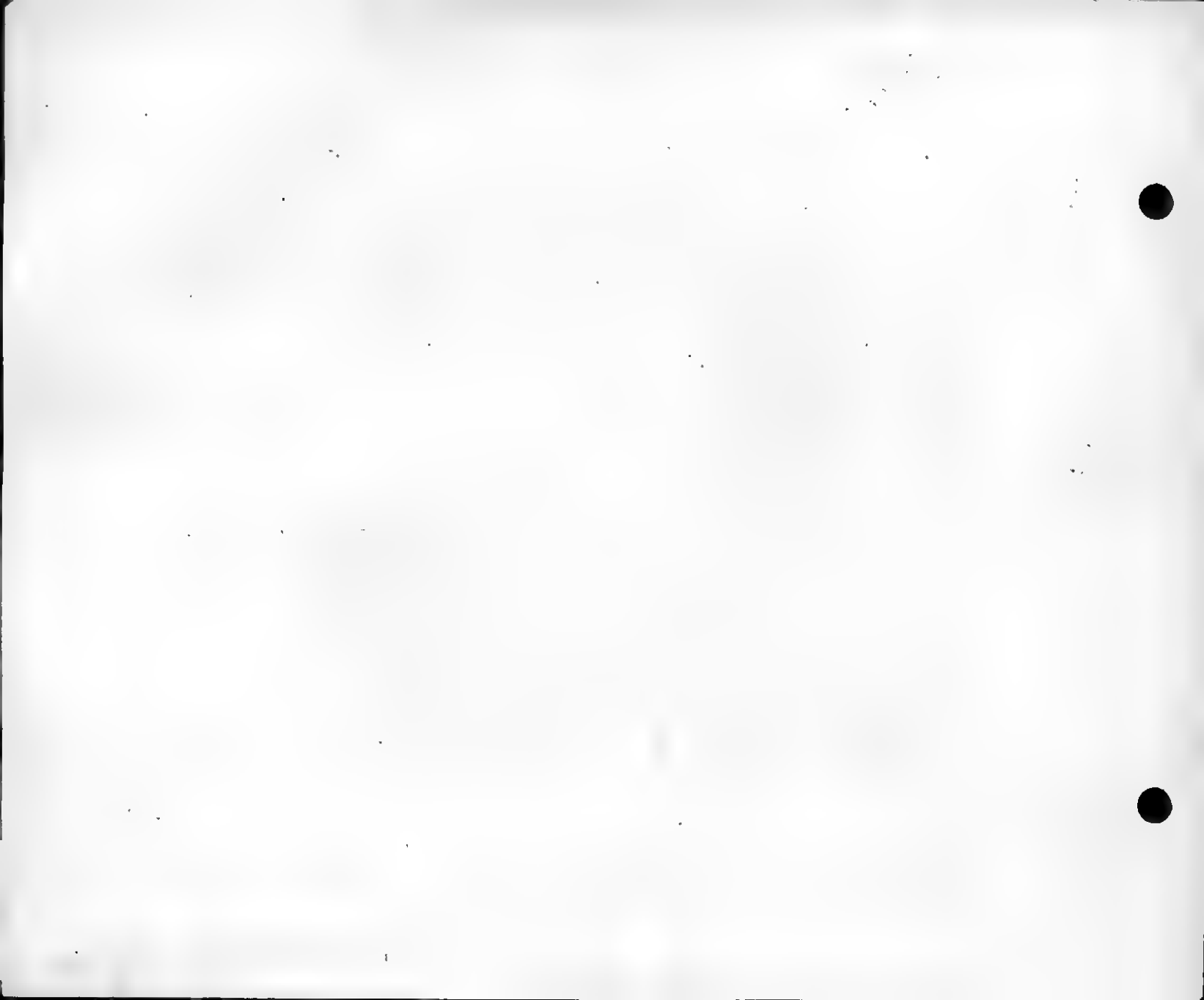
| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Katie LEE BARNES | | | 2a. DATE OF DEATH Month Day Year 11 1 68 | | | 2b. HOUR B:40 P.M. | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 8/1/02 | | 6. AGE (In years last birthday) 66 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY HOMES | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN MONKTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER BEG FALLS RD. | | 14. FATHER'S NAME First Middle Last ? DORSEY | | 15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) NO | | 16b. SOCIAL SECURITY NO 212-28-5409 | | 17. INFORMANT ALLINE THOMAS-MONKTON, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarct 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension + arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13, 1968, to 11/1, 1968, that (I) (we) last saw the deceased alive on 11/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rudiger Breiteneker, M.D. | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/2/68 | |
| 22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D. | | | | 22e. ADDRESS 6701 N. Charles Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY Stephenson's | | 23d. LOCATION (City or Town) (County) (State) Sparks, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR Wm. I. Chatman Jr. 1701 Mt. Culloden St. Balto., Md. | | | | 25a. REC'D BY REGISTRAR DATE NOV 6 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

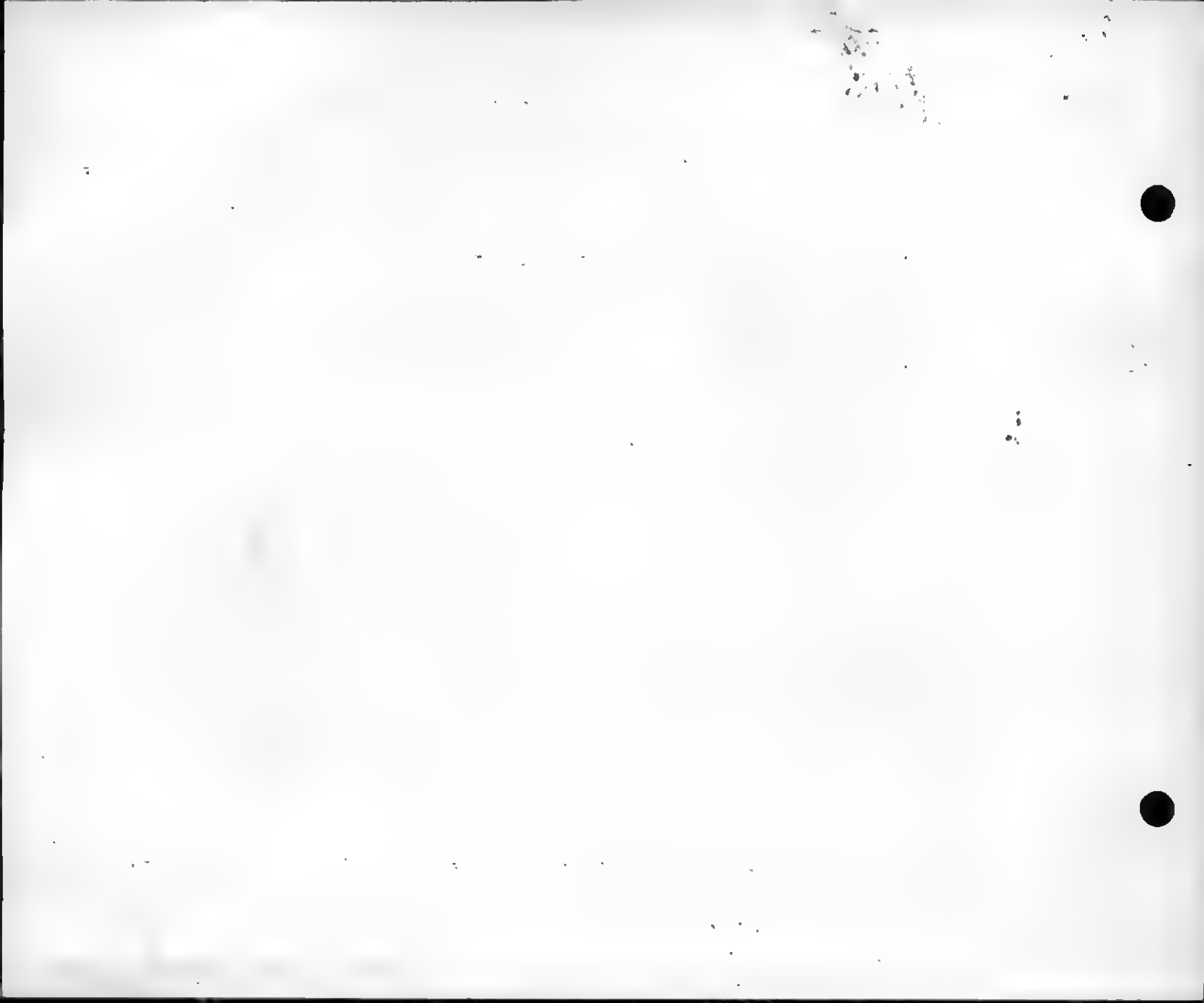
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------|--|--|--|------------------------|--|--|--|
| Item#24Film#G1J8 15459 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 15471 | | | | | | | |
| 1 DECEASED NAME (Type or print) Oakley Bashem | | | | | | | | | | | | First | | | | Last | | | | 2a. DATE OF DEATH Month 11 Day 30 Year 68 | | | | | | | | 2b. HOUR 6:30 M | | | |
| 3. SEX M. | | | | 4. RACE white | | | | 5. DATE OF BIRTH 4/30/1903 | | | | | | | | 6. AGE (In years last birthday) 65 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS M.N. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) FLOYD CTY KY | | | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Bal county Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Catoonsville | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SGS.H | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | | | 13b. COUNTY HARFORD | | | | 13c. CITY OR TOWN Street | | | | 13d. INSIDE CITY (Y/N) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER UNKNOWN. | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First JAMES Middle HARRY Last Bashem | | | | 15. MOTHER'S MAIDEN NAME First MARGARET Middle A Last TURNER | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. UNKNOWN | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. 7111 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-6- , 1937, to 11-30 , 1968, that (I) (we) lost the deceased alive on 11/30 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Scotlyn D | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 11-30-68 | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) EVELLO A. FELICE-M.D. | | | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL | | | | 22f. ADDRESS SGS.H. Bal to. Md. 21228 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md. | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Newell Funeral Home 1100 | | | | ADDRESS Reisterstown Rd. | | | | 25a. REC'D BY REGISTRAR DEC 12 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|--|--|--|--|
| <p>information taken from birth cert. Item# 43a.c.d Film# G406 11/15/68</p> <p align="right">15471</p> | | | | | | | | | | | | |
| 1 DECEASED NAME (Type as printed) 15460 BABY BOY BATES | | | | | | 2a DATE OF DEATH Month 11 Day 2 Year 1968 | | | 2b. HOUR 4:03pm | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH 11-2-68 | | | 6 AGE (In years last birthday) YRS. | | IF UNDER 1 YEAR MONTHS 15 DAYS 15 | | IF UNDER 24 HRS HOURS 15 MIN 15 | |
| 7a BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c CITY OR TOWN Lutherville | | 13d INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 18 Croftley Road | | | |
| 14. FATHER'S NAME First Robert Vincent Middle Bates Last Bates | | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Louisa Last Sparger | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Immaturity</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 761.5</p> <p>(b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</p> <p>Premature rupture of fetal membranes</p> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| <p>22a. I certify that (I) (this hospital) attended the deceased from 11/2, 1968, to 11/2, 1968, that (I) (we) last saw the deceased alive on 11/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> | | | | | | | | | | | | |
| 22b. SIGNATURE Rudiger Breitenecker DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED 11/12/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M. D. | | | | | | | | 22e. ADDRESS Greater Baltimore Medical Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 11/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Greater Balto. Med. Center | | 23d. LOCATION (City or Town) (County) (State) Towson, Balto. Md. | | | | | | |
| 24. FUNERAL DIRECTOR Rudiger Breitenecker ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

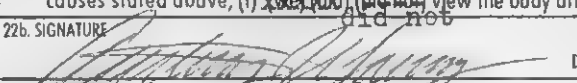
1

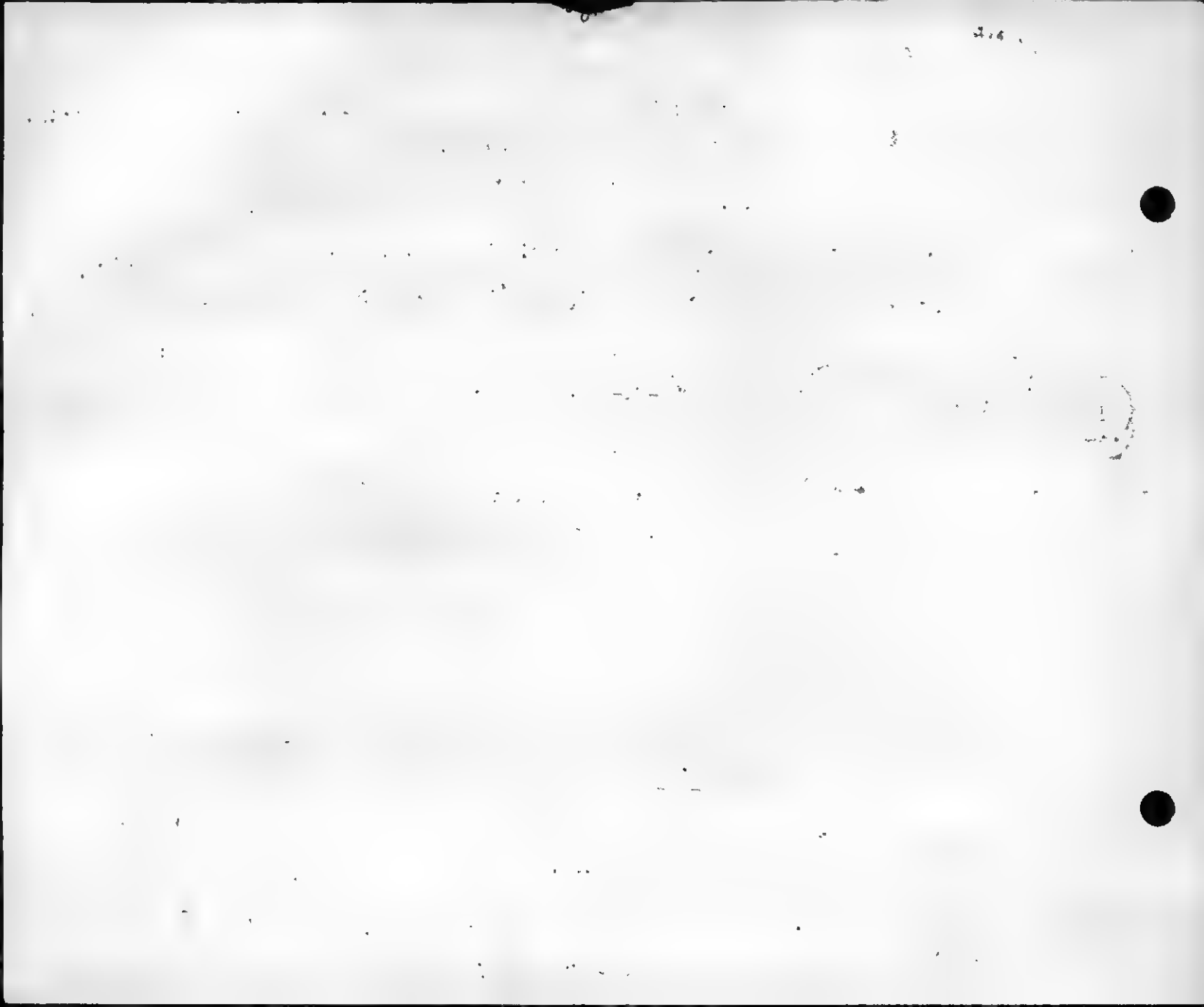
15462

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1547.1

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Frank Battaglia | | First Middle Last | | 2a. DATE OF DEATH Nov. 11, 1968 | | 2b. HOUR 10:15 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH May 5, 1886 | | 6. AGE (In years last birthday) 82 | |
| 7a. BIRTHPLACE (State or foreign country) Italy | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | |
| 10. CITY OR TOWN OF DEATH Catonsville, Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Shoemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Self | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Dominic | | First Middle Last | | 15. MOTHER'S MAIDEN NAME Rosa Castiglia | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 151-01-5358 | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) Arteriosclerotic cardiovascular disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) Generalized arteriosclerosis | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 9, 1966 , 19 66 , to November 11, 1968 , that (I) (we) last saw the deceased alive on 11/11/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE  | | DEGREE Anthony J. Young, M.D. | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-12-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE NOV 15 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemerson Cem | | 23d. LOCATION (City or Town) (County) (State) Bolton Rd. B. Ho. Md | |
| 24. FUNERAL DIRECTOR Robert Bush | | ADDRESS 2110 Bolton Rd. | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV 1/68

Item 5 Film 407 12/2/68 kk
Items 6, 13e, 15 & 17 Film 408 1/3/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15474

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME (Type or print) 15668 Raymond E. Bauer Sr. | | First Middle Last | | 2a DATE OF DEATH Month Day Year 11 23 1968 | | 2b. HOUR M | |
| 3 SEX Male | | 4 RACE Cau. | | 5. DATE OF BIRTH 4-15-1968 1889 | | 6 AGE (In years last birthday) 19 69 YRS. | |
| 7a BIRTHPLACE (State or foreign country) Baltimore | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md. | |
| 10 CITY OR TOWN OF DEATH Overlea (Rufal) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 Glenmore Avenue | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Printer | | 12b KIND OF BUSINESS OR INDUSTRY Printing | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Overlea | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 11 Glenmore Avenue 21236 | | 14 FATHER'S NAME First Middle Last Jacob Bauer | | 15 MOTHER'S MAIDEN NAME First Middle Last Sarah Glover | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No | |
| 16b. SOCIAL SECURITY NO 218-09-1310 | | 17. INFORMANT Mrs R.E. Bauer | | Address 11 Glenmore Avenue 21236 | | 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221 (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Cholecystitis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCAT ON Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April, 1955 , to 23 Nov, 1968 , that (I) (we) last saw the deceased alive on 22 Nov 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John C. Hyde | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11-25-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN C. HYDE | | 22e. ADDRESS 527 Belair Rd Balto 36 Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-26-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Road 21236 | | 25a. REC'D BY REGISTRAR DATE NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|------------------------------|--|---|---|-------------------------------------|--|--------------------------------|---------------|--|
| 1 DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M | |
| Lydia P. Becker | | | | | 11-2-68 | | | 8P | |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS M.N. |
| Female | White | | Nov. 19, 1881 | | 86 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Balto. Md. | U.S.A. | | | | Baltimore County Md | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 42 Lyndale Ave. | | Cook | | Well's Rest. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Baltimore | | | | 42 Lyndale Avenue | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 17. INFORMANT Address | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Gottlieb Schilpp | | Caroline Meisenhelder | | Mrs. Lydia C. Postuszny- 42 Lyndale Avenue | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | 220-01-0943 | | Mrs. Lydia C. Postuszny- 42 Lyndale Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular</u> | | | | | | | | | May 1968 |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissecting</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>4321</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| <u>Herpes Zoster of C, not left. Hx of Parkinsonism</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>4</u> , to <u>2 NOV</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2 NOV</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John C. Hyle</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>11-4-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>JOHN C. HYLE M.D.</u> | | | | 22e. ADDRESS <u>7527 BELAIR ROAD 21236</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11-6-68 | | Parkwood Cemetery | | Balto. Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John C. Miller Inc. 415 Belair Rd. - 21206 | | | | DATE <u>NOV 12 1968</u> | | <u>Charles Judge</u> | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

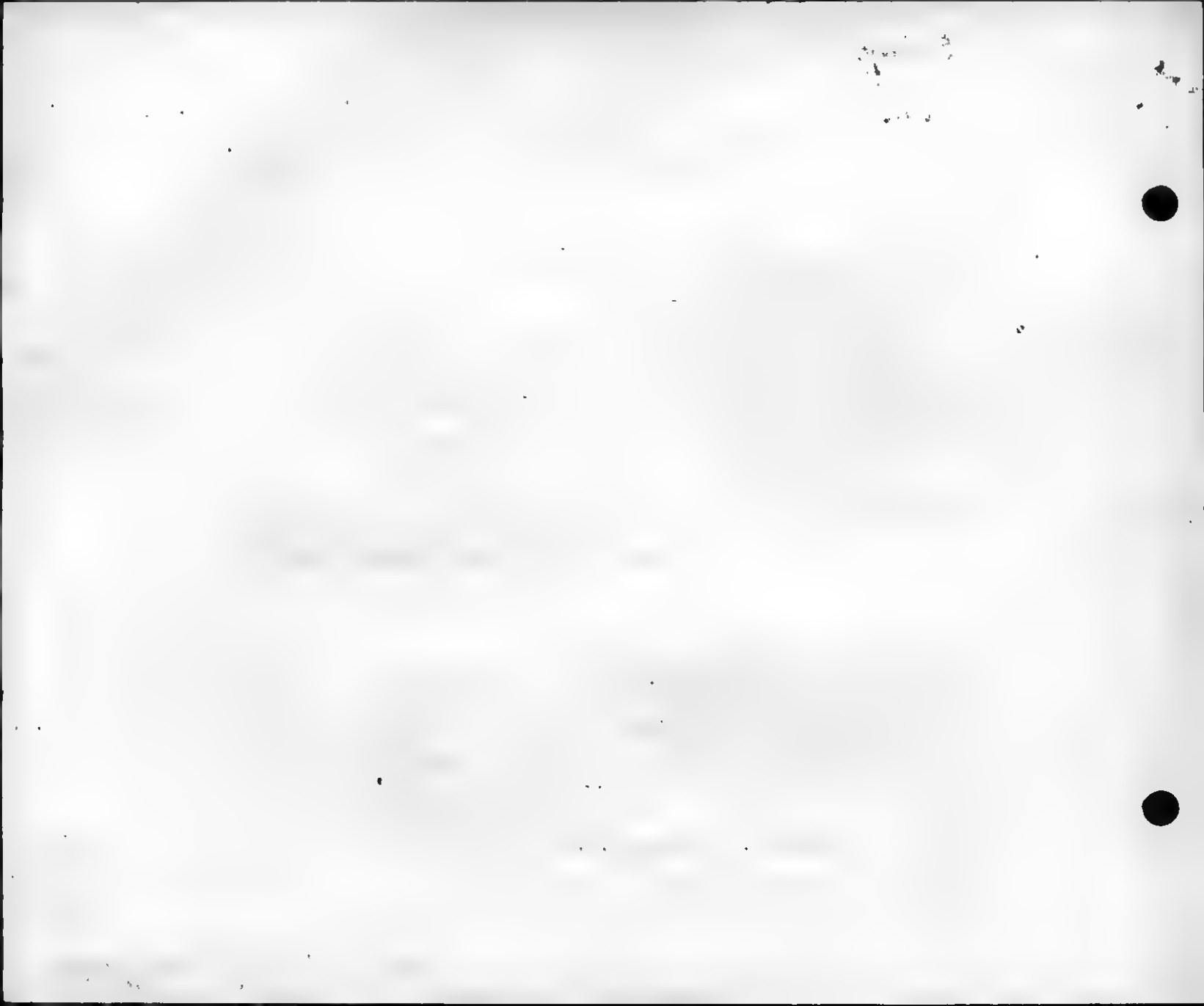
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15464

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15476

| | | | | | | | | | | | | |
|---|-------------------------|---|---|---|--|---|--|---|-----------------------------------|--|--|--|
| 1. DECEASED NAME (Type or Print) JOHN | | First MELVIN | | Middle BECRAFT, JR. | | Last | | 2a. DATE KNOWN OF DEATH Month Nov. Day 8, Year 1968 | | 2b. HOUR 7:50A | | |
| 3 SEX Male | 4. RACE White | 5. DATE OF BIRTH Jan. 1-1940 | 6. AGE (in years last birthday) 28 YRS. | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | | 8. UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN. | | 2c. DATE PRONOUNCED DEAD Month Nov. Day 8, Year 1968 | | 2d. HOUR 7:50A | | |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grounds of Goucher College | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Res. since before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2403 E Monument St 3600 Erdman Avenue | | | | |
| 14. FATHER'S NAME First John Middle Melvin Last Becraft | | | | 15. MOTHER'S MAIDEN NAME First Catherine Middle Hollmeyer Last | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | |
| 16b. SOC. SEC. SECURITY NO. 218-36-2301 | | | | 17. INFORMANT Mrs. June Becraft | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Carbon Monoxide DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 11-11-68 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. ?? P.M. Nov. ?? 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Asphyxiated | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) College Ground | | 21f. LOCATION Street or R.F.D. No Goucher College | | City or Town Baltimore | | County M.D. | | State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum | | EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-11-68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City or Town) Balto. | | County Md. | | State | | |
| 24. FUNERAL DIRECTOR Shelma A. Hoffmann | | | | ADDRESS 3218 Hudson St | | 25a. READ BY REG. STRAR NOV 12 1968 | | 25b. REG. STRAR'S SIGNATURE Charles Judge | | | | |



CERTIFICATE OF DEATH

15471

| | | | | | | | | | | | | | | | |
|--|--|---|--------|---|----------------------------|---|-----|-------------------------------------|------|---|--|--|--|-----------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month | | Day | | Year | 2b. HOUR | | | | | |
| ANNA | | M | BEHN | | NOV. | | 4, | | 68 | 9:15 A.M. | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH Aug. 12, 1883 | | 6. AGE (In years last birthday) | | 8.5 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not at home, give street address) HOUSE IN THE PINES AV. | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 1937 W. Lombard St. | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | | | | | |
| Unknown | | | | | | | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | | | | | |
| No | | None | | Frieda A. Bruce, | | 902 Palladi Dr. Balto | | 21227 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Ischemic Heart Disease | | | | | | | | | | 3 wks. | | | | | |
| 44- Due to, or as a consequence of | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) Generalized arteriosclerosis | | | | | | | | | | 15 yrs. | | | | | |
| Due to, or as a consequence of | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 4-2-1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC | | 21f. LOCATION Street or RFD No | | City or Town | | County | | State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-3-1968, to 11-4-1968, that (I) (we) last saw the deceased alive on 11-3-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE WILMER K. GALLAGER, SR. M.D. | | | | | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11-4-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | WILMER K. GALLAGER, SR. | | 22e. ADDRESS | | 6209 FREDERICK AVE. BALTO. 28, 2nd. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | |
| Burial | | 11-6-68 | | Meadowridge Cemetery | | Dorsey Rd., Baltimore Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| HOWARD H. HUBBARD | | | | 4107 WILKENS AVE. 21229 | | NOV 7 1968 | | J. Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

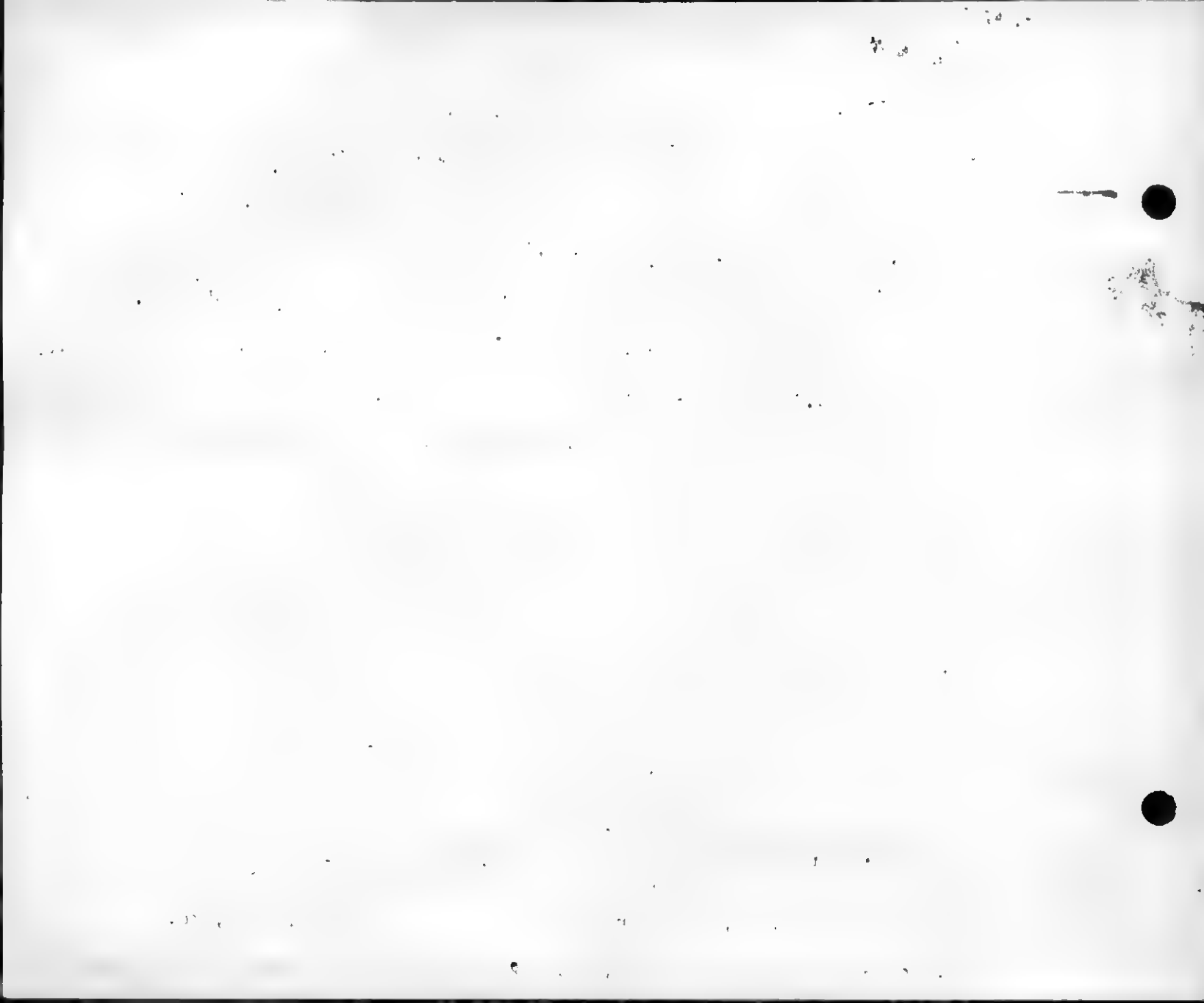
2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) RUTH | | | First V. Middle Bentley. Last | | | 2a. DATE OF DEATH Month Nov. Day 29 Year 1968 | | | 2b. HOUR 3:30 AM | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH Mar. 26, 1875 | | | 6. AGE (In years last birthday) 93 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Aged Women's + Men's Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY --- | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Edward Middle DAVIS Last | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle Elizabeth Last Turner | | | 13e. STREET AND NUMBER 33175 Paulding Ave. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO 215-54-1730 | | | 17. INFORMANT DAISY E. HAMILTON | | | Address 615 Chestnut Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic Cardio-Vascular Disease 4127 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14, 1939 , to Nov. 29, 1968 , that (I) (we) last saw the deceased alive on Nov. 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Newland Edward Day M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED Nov. 29, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Newland Edward Day | | | | | | | | 22e. ADDRESS 4-E-33rd St Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Nov. 30, 68 | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | |

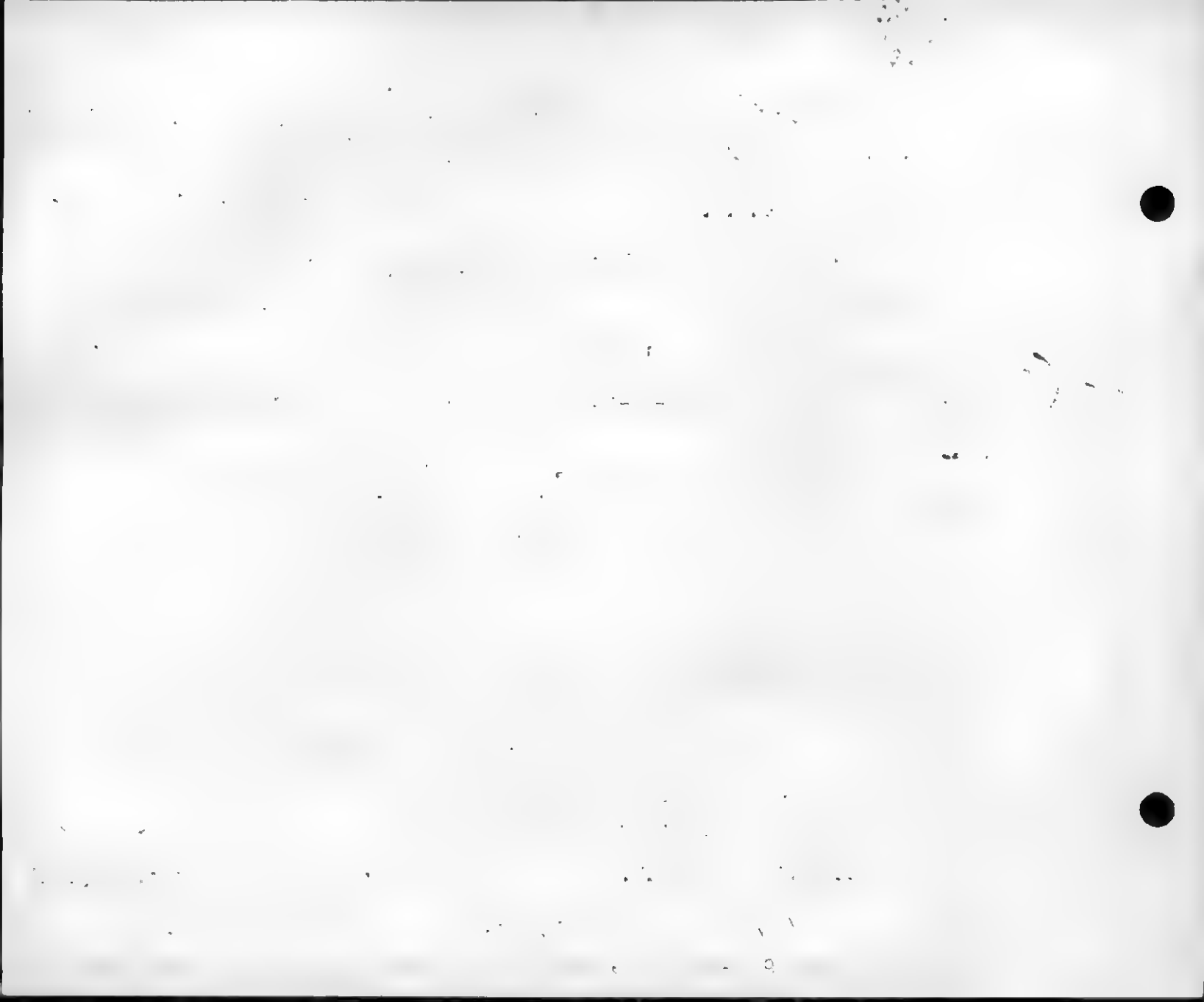


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 15467 | | | | | | | | | | | |
| 15479 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) MARIA | | | First Maria Middle Maria Last PERLUTI | | | 2a. DATE OF DEATH Month 11 Day 19 Year 1968 | | | 2b. HOUR 2:45 PM | | |
| 3 SEX FEMALE | | | 4 RACE White | | | 5 DATE OF BIRTH 1-18-1890 | | | 6 AGE (In years last birthday) 78 YRS | | |
| 7a BIRTHPLACE (State or foreign country) Italy | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md. | | |
| 10 CITY OR TOWN OF DEATH TOWSON | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CINCINNATI MANOR NURSING HOME | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution- Residence before admission) Maryland | | | 13b. COUNTY Parkville | | | 13c CITY OR TOWN Parkville | | | 13e STREET AND NUMBER 7016 Marietta Ave | | |
| 14. FATHER'S NAME First ? Middle Cinque Last ? | | | 15. MOTHER'S MAIDEN NAME First Brace Middle ? Last ? | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO. 212-01-1818 | | |
| 17. INFORMANT Mrs Anita Balsame | | | Address 7406 Forrest Ave | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hepaticemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17/68 , 19 68 , to 11/18/68 , 19 68 , that (I) (we) last saw the deceased alive on 11-18-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Sebastian Russe M.D. | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 11/20/68 | | |
| 22d. PHYSICIAN'S NAME (Type) Sebastian Russe M.D. | | | 22e ADDRESS 5017 Harford Rd Baltimore, Maryland | | | 23a. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | | 23b. DATE 11/23/68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/23/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland | | |
| 24 FUNERAL DIRECTOR Leonard J Ruck Inc, Baltimore, Maryland | | | ADDRESS | | | 25a. REC'D BY REGISTRAR NOV 22 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



FOR STATE HEALTH DEPT.

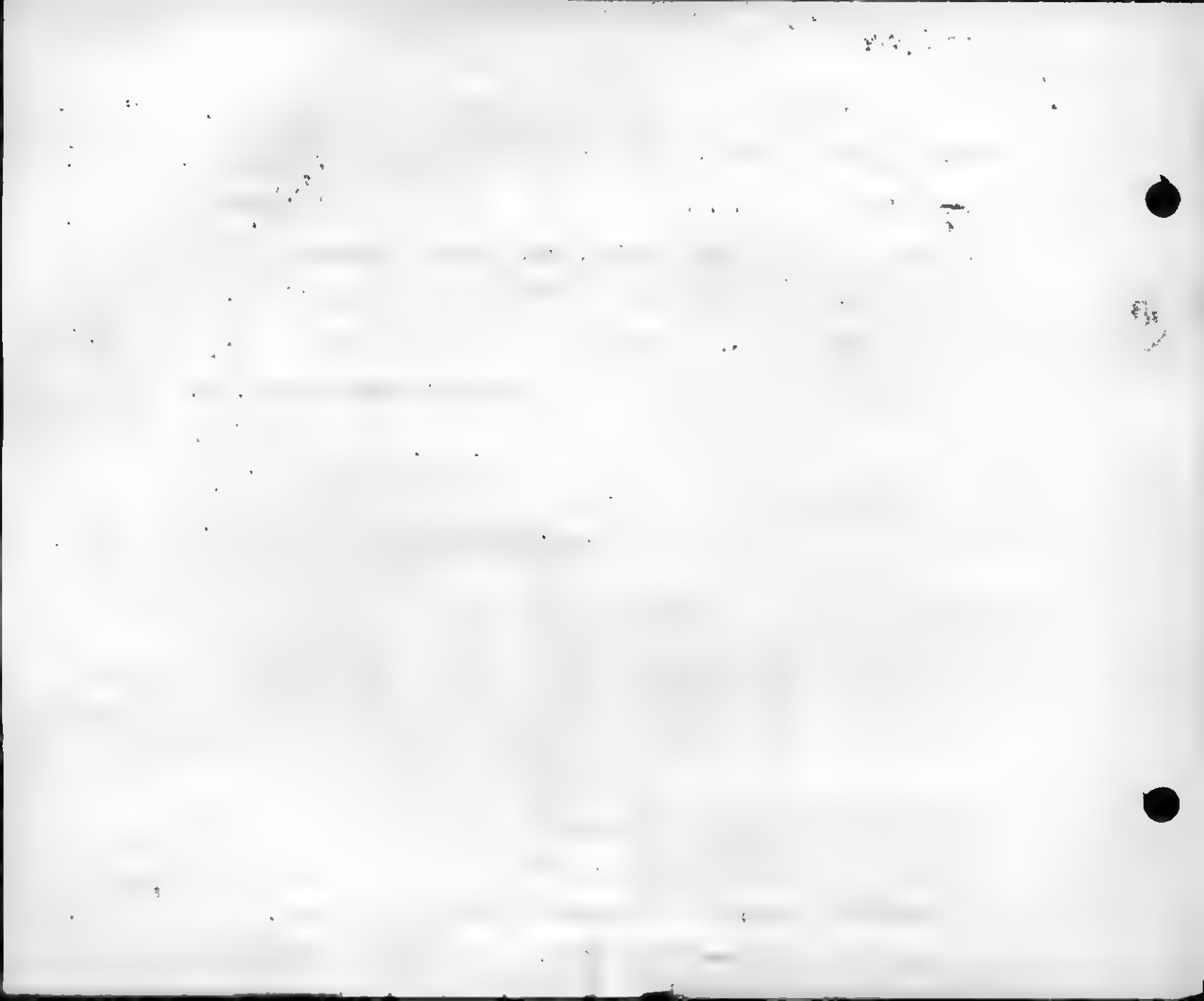
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15468

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--------|------------------------------|--|---|------------------------------------|---|--|---|---|--|
| 1. DECEASED NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH Month Day Year | | | | 2b. HOUR OF DEATH M |
| Frances Maud Berry | | | | | | November 21 1968 | | | | 6:05 PM |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR OF DEATH M |
| Female | White | May 24, 1875 | 93 YRS | MONTHS DAYS | | HOURS MIN | | November 21 1968 | | 7:00 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Detroit Mich. | | U.S.A. | | | | Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | | Greater Balto. Med. Centre | | | Homemaker | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Balto. | | Towson | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Dixie Dr. | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | ADDRESS | | | | |
| John A. Berry | | | Emma S. Read | | | Presbyterian Home Towson, Md. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | | | |
| NO | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> | | | | | | | | | | <u>Sudden</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease - 10 yrs</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Heart Disease - 10 yrs</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY? | | | | |
| 11/19/68 | | | Ischemic Heart Disease - 10 yrs | | | Left | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18) | | | | |
| CAUSE OF DEATH | | | 6:00 PM Nov 18 1968 | | | Fell in Hall at Nursing Home | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or RFD No City or Town County State | | | | |
| Nursing Home | | | Nursing Home | | | Dixie Drive - Towson Balto. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | ASSISTANT MEDICAL EXAMINER | | | 22b. DATE SIGNED | |
| Charles F. O'Donnell | | | | | | | | | 11/27/68 | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | |
| Charles F. O'Donnell, M.D. | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or town) (County) (State) | | |
| Cremation | | | 11/23/1968 | | Greenmount Crematory | | | Balto. Md. | | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Mitchell Wiedefeld Home 6500 York Rd. | | | | | | DATE NOV 26 1968 | | f. j. j. | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|--|--|---|---|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 15468 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Lydia P. Berry | | | | | | Month Day Year | | 3 30 PM | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Female | | White | | Oct. 25, 1886 | | 82 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | |
| Baltimore | | U. S. | | | | Baltimore Md | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Catonsville | | | 815 Braeside Road | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY, UNITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | Catonsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 815 Braeside Road | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Deceased Smith | | | Deceased | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | | |
| no | | | -- | | Mr. Clayton T. Berry, 815 Braeside Rd. Catonsville | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic schistocytic C.V. dis. 5 years</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4 <u>Staphylococcus</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 27, 1968</u> to <u>Nov. 6, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| <u>Christian Mass</u> | | <u>11/7/68</u> | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Dr. Christian Mass | | 21 St. Johns Lane, Ellicott City, Md. | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | Nov. 3, 1968 | | Loudon Park Cemetery | | Baltimore Maryland | | | | |
| 24 FUNERAL DIRECTOR ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Witzke Funeral Dir., 4101 Edmondson Ave. Balto. | | DATE NOV 8 1968 | | <u>Charles Judge</u> | | | | | | |

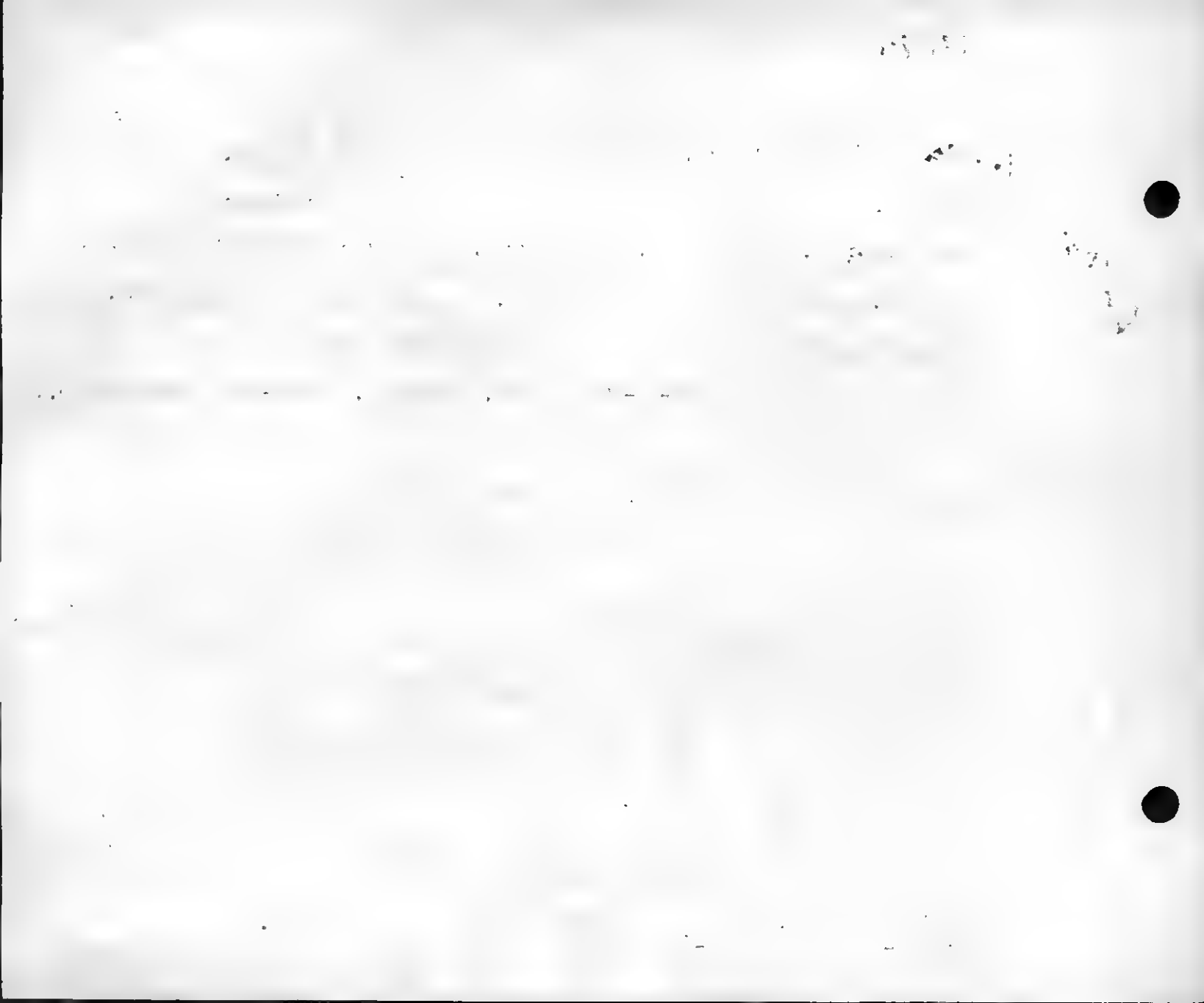


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|---------|------------------|--|-----------------|----------|--|-----------|---------|--|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| JOHN RUSSELL BIRNEY | | | | | | Month Day Year | | | 9:54 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | 7. UNDER MONTHS | 8. YEARS | 9. IF UNDER 24 HRS. DAYS | 10. HOURS | 11. MIN | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| Male | White | June 25, 1925 | 43 YRS | | | | | | Month Day Year | | 9:45 PM |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Balto., Md. | | | USA | | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson Balto Co. | | | St. Joseph Hospt. | | | Sales Representative | | | Tobacco | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Balto. | | | | | | 411 Cedercroft Rd. | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Russell E. Birney | | | Hildagarde Raabe | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | 220-18-5043 | | | Mrs. Russell E. Birney | | | 411 Cedercroft Rd. 12 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremic Poison</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Ingestion of Bichloride</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>of Mercury</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>970</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>11/28/68</u> | | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | ADDRESS (Street, city, town or county) | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 12/2/68 | | | Cathedral Cemetery | | | Balto. | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Mitchell-Wiedefeld Home -6500 York Rd. 21212 | | | DEC 3 1968 | | | Charles Judge | | | | | |

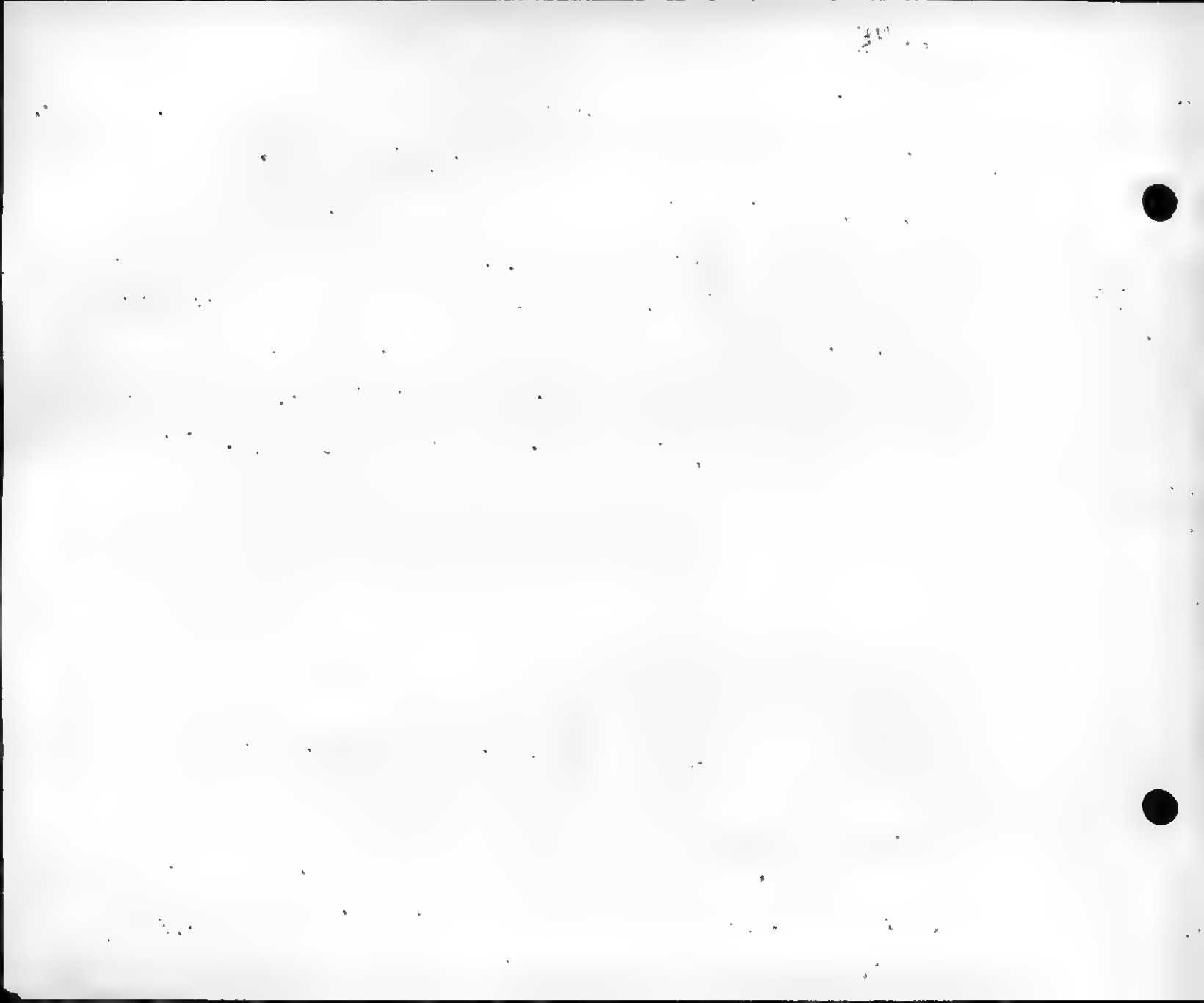


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15483
30M REV 1-68

| MIDDLE | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|---|---|---|--------------|----------------------------|--|--|
| 15473 | | | | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 15483 | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) First Middle Last Fannie C Bischoff | | | | | | 2a. DATE OF DEATH Month/Day/Year 11/26/68 | | | 2b. HOUR 9:00 M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH 8/20/96 | | | 6 AGE (in years lost birthday) 72 YRS. | | 7 UNDER 1 YEAR MONTHS DAYS | | 7 UNDER 24 HRS. HOURS MIN. | | |
| 7a BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Cotonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 262 Blakeney Rd | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY Own Home | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b COUNTY Baltimore | | | 13c CITY OR TOWN Cotonsville | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER 262 Blakeney Rd | |
| 14. FATHER'S NAME First Middle Last Unknown | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b SOCIAL SECURITY NO 114526592 | | | 17 INFORMANT Address Lynn F Morgan 262 Blakeney Rd | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Rheumatic Valvular Heart Disease</u> 62yrs DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1966</u> , to <u>Nov 26, 1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Nov 26, 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE A. Bradley Dougherty M.D. | | | | | | 22c DATE SIGNED | | 22d PHYSICIAN'S NAME (Type) A. Bradley Dougherty | | | | | |
| 22e ADDRESS 1264 Francis Ave. Balto Md 21227 | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 11/29/68 | | 23c NAME OF CEMETERY OR CREMATORY Greenwood Cemetery Howard County, Maryland | | 23d LOCATION (City or Town) (County) (State) Baltimore Md | | | | | | | |
| 24. FUNERAL DIRECTOR Lorraine Tim 1328 Sulphur Sp. Rd. | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon in papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

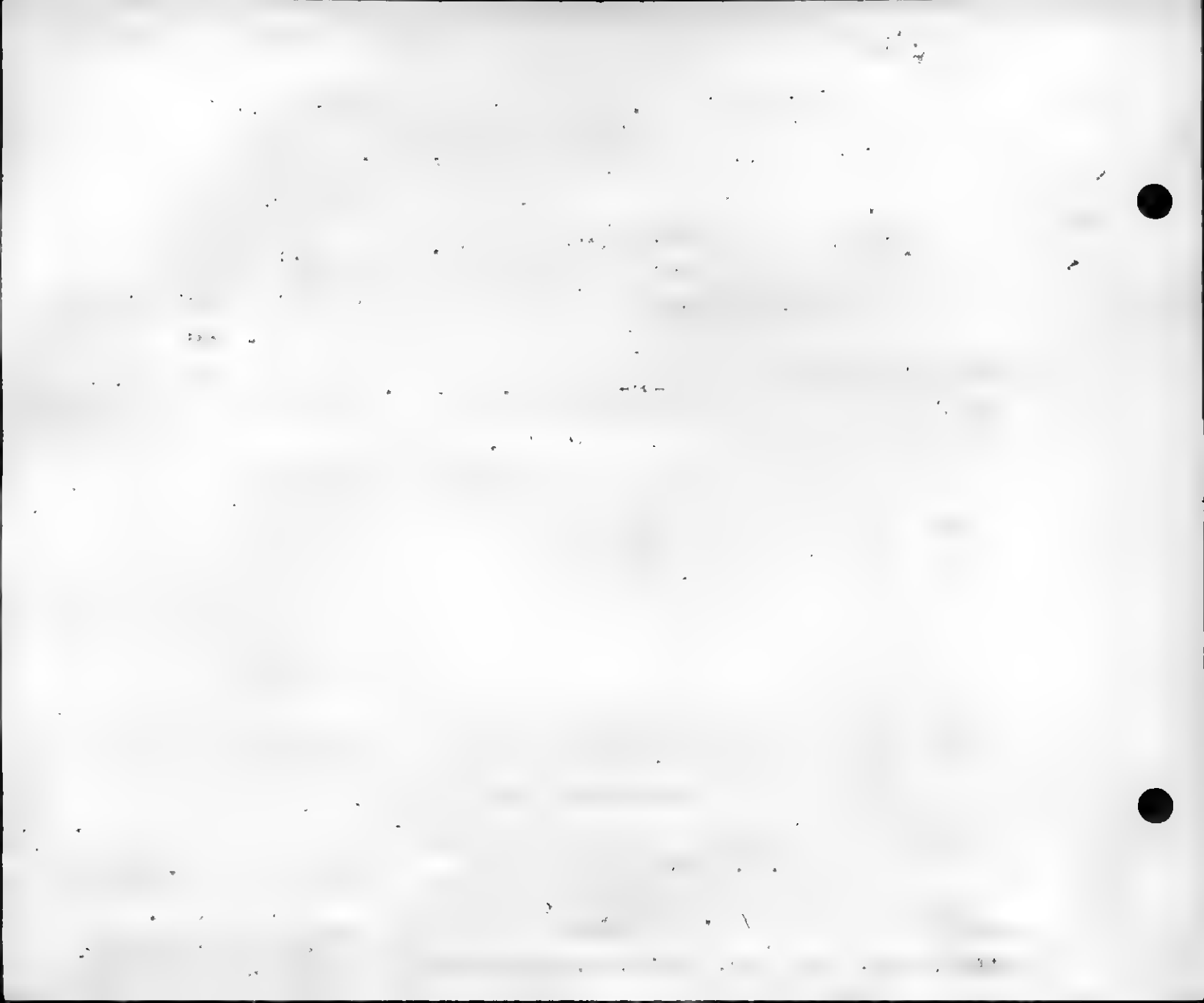
VR A15 (4)
30M REV. 1/70

15472

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1548

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Josephine E. Blanchard | | 2a. DATE OF DEATH Month November Day 7 Year 1968 | | 2b. HOUR 11:20 AM | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH May 15, 1897. | |
| 6. AGE (In years last birthday) 71 YRS. | | 7. BIRTHPLACE (State or foreign country) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH Balto. 21212 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1109 Regester Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of work-life, even if retired) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto | |
| 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1109 Regester Ave. | |
| 14. FATHER'S NAME First Joseph Middle Spies Last Spies | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates or service) | | 16b. SOCIAL SECURITY NO. 218-03-2244D | | 17. INFORMANT Mr. Melvin F. Blanchard Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thromboses 453.9 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Approximate interval between onset and death: SUPPEN 10 yrs | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 350.9 |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 58 , to 11/7 , 19 68 , that (I) (we) last saw the deceased alive on 11/7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE L. P. Berger MD | | 22c. DATE SIGNED 11/8/68. | | 22d. PHYSICIAN'S NAME (Type) L. P. Berger MD | |
| 22e. ADDRESS 8100 Hafford Rd. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 23b. DATE 11/11/68. | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR NOV 8 1968 | | 25b. REGISTRAR'S SIGNATURE John A. Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|--|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) Frederick | | | First Middle Last Blimline | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> Nov. 3 - 1968 | | | 2b. HOUR 9:00 M | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH 4-26-1896 | | 6. AGE (In years last birthday) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Nov. 3 - 1968 | | | |
| 7a. BIRTHPLACE (State or foreign country) md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTL - Md | | | | |
| 10. CITY OR TOWN OF DEATH Balto | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 4606 Plainfield Rd | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3716 Foster Ave. | | | |
| 14. FATHER'S NAME First Middle Last Andrew Blimline Fredericka | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rode | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | 16b. SOCIAL SECURITY NO. 216-05-4739 | | 17. INFORMANT Mrs. Anna Blimline | | | | ADDRESS 3716 Foster Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-L disease | | | | | | | | | | | | | |
| 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 4221 Diabetes Mellitus | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year Nov 3 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 11/5/68 | | | | |
| EXAMINER'S NAME (Type) M.B. DAVIS M.D.-6800 Maple St. Baltimore, Md. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 11-7-68 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | | | 23d. LOCATION (City or Town) (County) (State) Balto Md. | | | |
| 24. FUNERAL DIRECTOR Theresa A Hoffman | | | | | | ADDRESS 3218 Hudson St | | 25a. REC'D BY REG STRAR NOV 6 1968 | | 25b. REG STRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

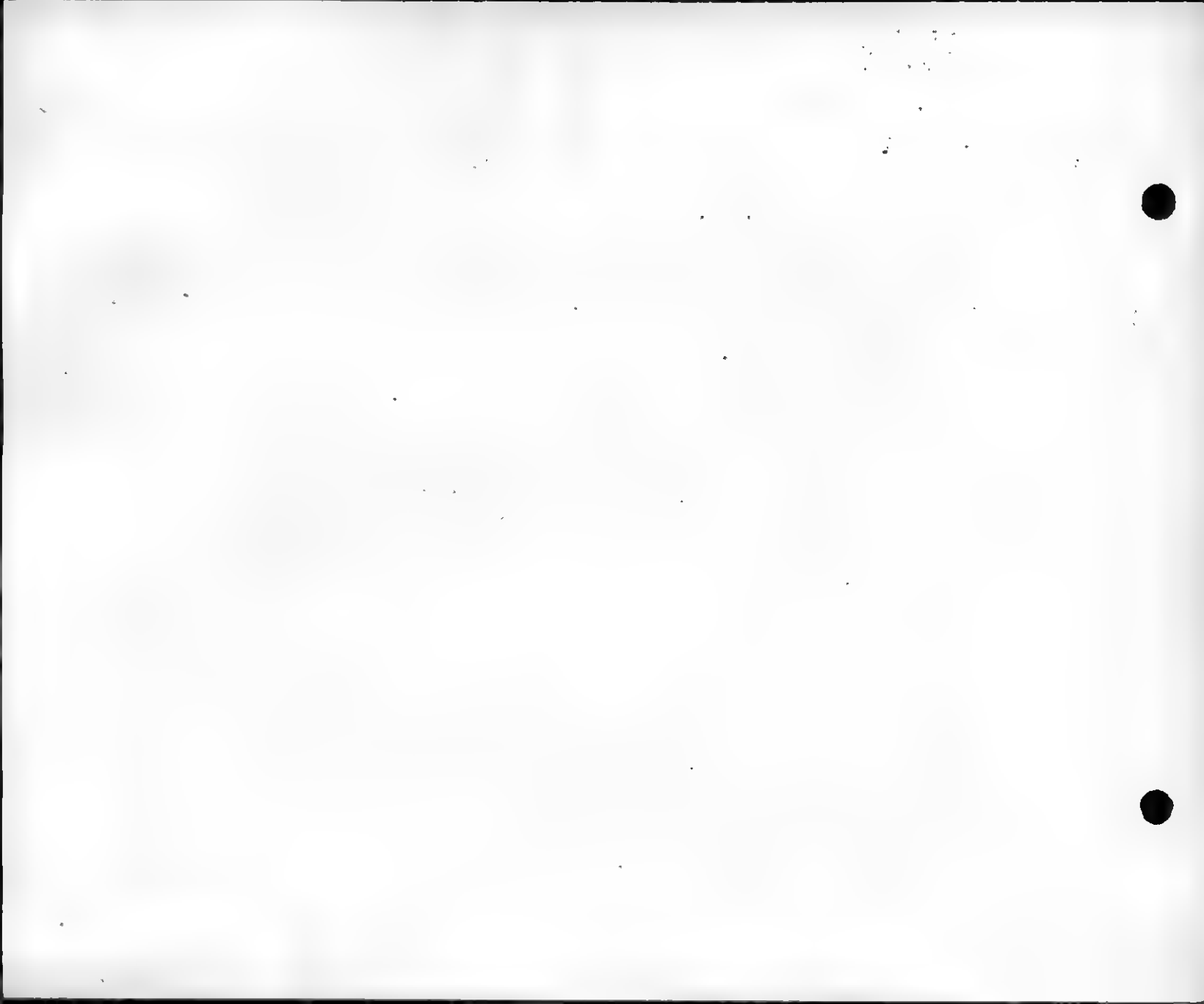
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16

15474

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15486
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME (Type or print) George | | First Middle Last Blucher | | 2a DATE OF DEATH Month 11 Day 12 Year 1968 | | 2b HOUR 12 MIN 15 PM | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH June 21, 1889 | | 6 AGE (In years lost birthday) 79 YRS. | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore, Md. | |
| 10 CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Oil Mobil | | 12b KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Kingsville | | 13d INSURE CITY (JULY 75) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME First George Middle T. Last Blucher | | 15 MOTHER'S MAIDEN NAME First Agnes Middle Pfeifer Last White Hall, Md | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | |
| 16b SOCIAL SECURITY NO 334-20-3738 | | 17 INFORMANT Address Mrs Norma M. Price 112A West Liberty Road | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis, right hemiplegia DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic cardiovascular disease; Atrial fibrillation, grade IV DUE TO, OR AS A CONSEQUENCE OF (c) 443X | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchopneumonia | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a I certify that (this hospital) attended the deceased from 10/17/ , 19 68 , to 11/12/ , 19 68 , that (we) lost the deceased alive on 11/12/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Gualberto Gokim, Jr. | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c DATE SIGNED 11/12/68 | | | |
| 22d PHYSICIAN'S NAME (Type) Gualberto Gokim, Jr. | | 22e ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 11/16/68 | | 23c NAME OF CEMETERY OR CREMATORY St. Michael Cemetery | | 23d LOCATION (City or Town) (County) (State) Baltimore Co. Md. | |
| 24 FUNERAL DIRECTOR LASSAHU FUNERAL HOME | | ADDRESS 7401 Belair Rd. BALTO. MD. | | 25a REC'D BY REGISTRAR NOV 15 1968 | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |

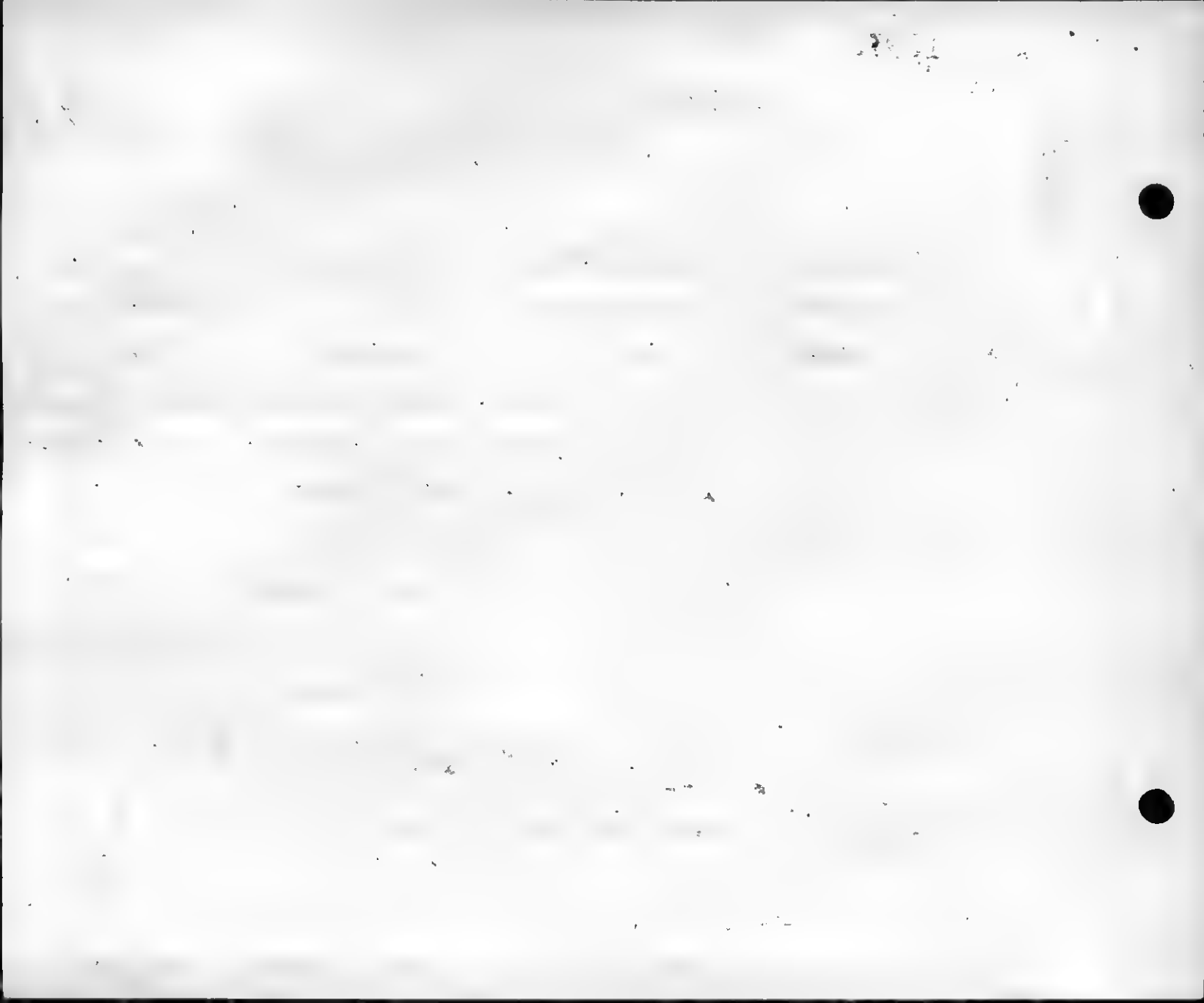


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

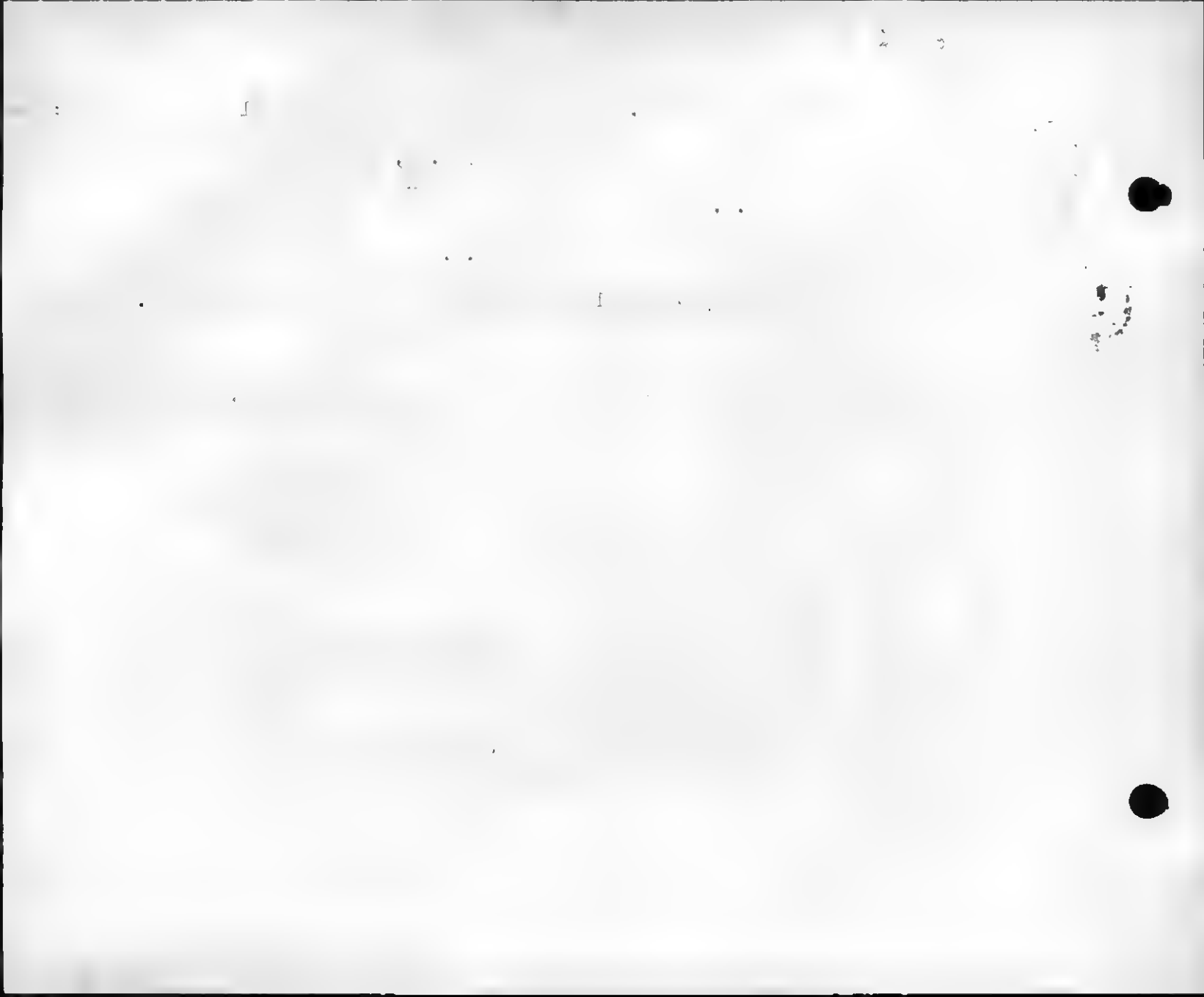
| <div style="text-align: center;"> <div>15475</div> <div> <div>15487</div> <div> <div>1</div> <div>15487</div> </div> </div> </div> | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) Frances Franciszka Kraxiski | | | | | | First Frances Middle Kraxiski Last Bober | | 2a. DATE OF DEATH Month II Day 4 Year 1968 | | 2b. HOUR 9 30 AM | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH April 5 1885 | | 6. AGE (In years lost birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Poland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 6916 Fait Avenue | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Balto, Md | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6916 Fait Avenue | | | |
| 14. FATHER'S NAME First Anthony Middle Wegzyn Last | | | | 15. MOTHER'S MAIDEN NAME First Victoria Middle Telka Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) | | 17. INFORMANT Address Helen Lombardi 6916 Fait Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC C.V. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OCT 29/68 ? | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 430 CERE BRO VASCULAR HEMMORRHAGE JUNE/68 | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. NONE Month NONE Year NONE | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) NONE | | | | | | | |
| 21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) NONE | | 21f. LOCATION Street or R.F.D. No. NONE City or Town NONE County NONE State NONE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 15, 1968 to NOV 4, 1968 , that (I) (we) lost saw the deceased alive on NOV 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE E. G. Schimunek M.D. DEGREE | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-5-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) MANUEL A SCHIMUNEK MD | | | | | | 22e. ADDRESS 8425 EAST AVE 31224 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-7-1968 | | 23c. NAME OF CEMETERY OR CREMATORY St Stanislaus Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15476 CERTIFICATE OF DEATH 15488 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mary | | | C. Bolger | | | Month 10 Day 5 Year 68 | | 9:45am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Sept. 1, 1890 | | 78 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Baltimore | | U.S. | | | | Baltimore County Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore 21228 | | | Caton Ridge N.H. | | | Maid | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | | Anne Arundel | | | Baltimore | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Thomas Bolger | | | Bridget Fleming | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No | | | 214-26-5954 | | | Caton Ridge Nursing Home, 329 Harlem Lane | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7 shock | | | | | | | | | 2 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) Massive Gastric Hemorrhage | | | | | | | | | 4 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 1. Hip Fracture Old - Severity | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30-1968, to 11-5-1968, that (I) (we) lost the deceased alive on 11-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cesar Valle Cervero | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-5-68 | |
| 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO | | | | | | 22e. ADDRESS 3629 Liberty Rd | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 11-8-68 | | Cathedral Cmo. | | Baltimore | | Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Foley-Corcoran & Co | | | | Catonville, Md. | | DATE NOV 12 1968 | | J. Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

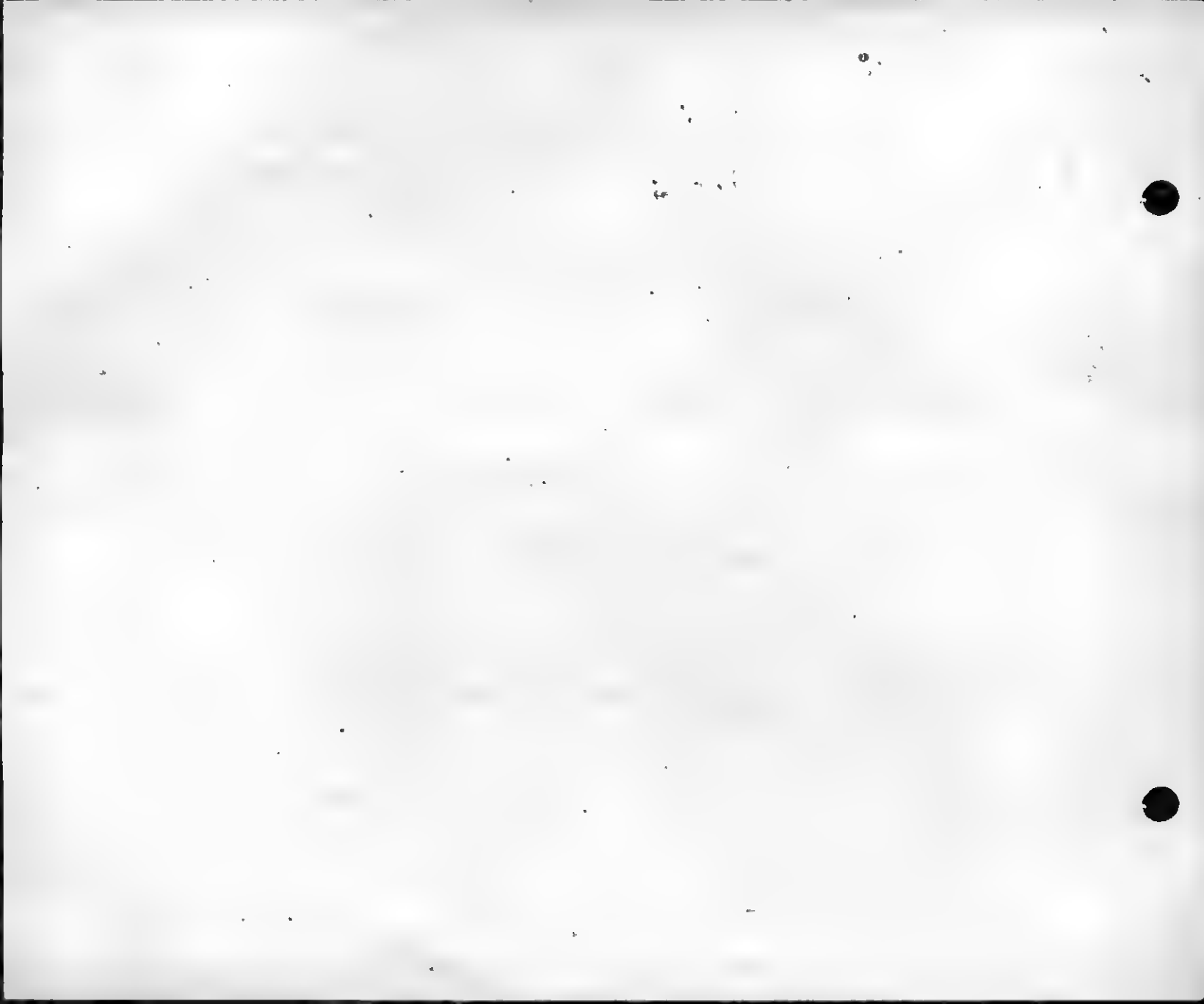
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15477

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15489

| | | | | | | | | | | |
|---|-----------------|--|---------------------|--|--|---|--|--|----------------|--|
| 1 DECEASED-NAME (Type or Print) <i>Bentley Elbridge Bosson</i> | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>11</i> Day <i>17</i> Year <i>1968</i> | | | | 2b. HOUR <i>M</i> | | |
| 3 SEX <i>M</i> | 4 RACE <i>W</i> | 5 DATE OF BIRTH <i>Aug 3 1910</i> | 6 AGE <i>58</i> YRS | F UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>10</i> | | IF UNDER 24 HRS HOURS <i>10</i> MIN. <i>30</i> | | 2c. DATE PRONOUNCED DEAD Month <i>11</i> Day <i>17</i> Year <i>1968</i> | | 2d. HOUR <i>11:30</i> <i>M</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>Ind.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH <i>Balto</i> | | | | |
| 10 CITY OR TOWN OF DEATH <i>Balto</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1704 Edgewood Rd.</i> | | | | 12a. USAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Salesman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>(Employee)</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Ind.</i> | | 13b. COUNTY <i>Balto</i> | | 13c. CITY OR TOWN <i>Balto</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>1704 Edgewood Rd.</i> | | |
| 14 FATHER'S NAME First <i>Reed</i> Middle <i>Bosson</i> Last <i>Bosson</i> | | | | 15 MOTHER'S MAIDEN NAME First <i>Georgina</i> Middle <i>Mc</i> Last <i>Caulery</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO <i>215-01-1617</i> | | 17 INFORMANT <i>Joseph H. Bosson</i> | | | | ADDRESS <i>1704 Edgewood</i> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion - arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Hypertensive arteriosclerotic Cardiovascular Disease</i> (b) <i>Hypertensive arteriosclerotic Cardiovascular Disease</i> (c) <i>Chronic congestive failure</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201 Chronic congestive failure</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>—</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>—</i> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>—</i> | | 21b. TIME OF INJURY Month, Day, Year <i>—</i> HOUR A.M. <i>—</i> P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>—</i> | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>—</i> | | 21f. LOCATION Street or R.F.D. No. <i>—</i> | | City or Town <i>—</i> | | County <i>—</i> | State <i>—</i> | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <i>FT KASIK JR</i> | | | | EXAMINER'S NAME (Type) <i>FT KASIK JR</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASS STANT MED. CAL. EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>11/17/68</i> |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) <i>—</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11-20-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i> | | 23d. LOCATION (City or Town) <i>Balto. Co. Maryland</i> | | (County) <i>—</i> | | (State) <i>—</i> |
| 24. FUNERAL DIRECTOR <i>Johnson Funeral Home</i> | | | | ADDRESS <i>21204 8521 Loch Raven Blvd.</i> | | 25a. REC'D BY REGISTRAR <i>NOV 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>—</i> | | |

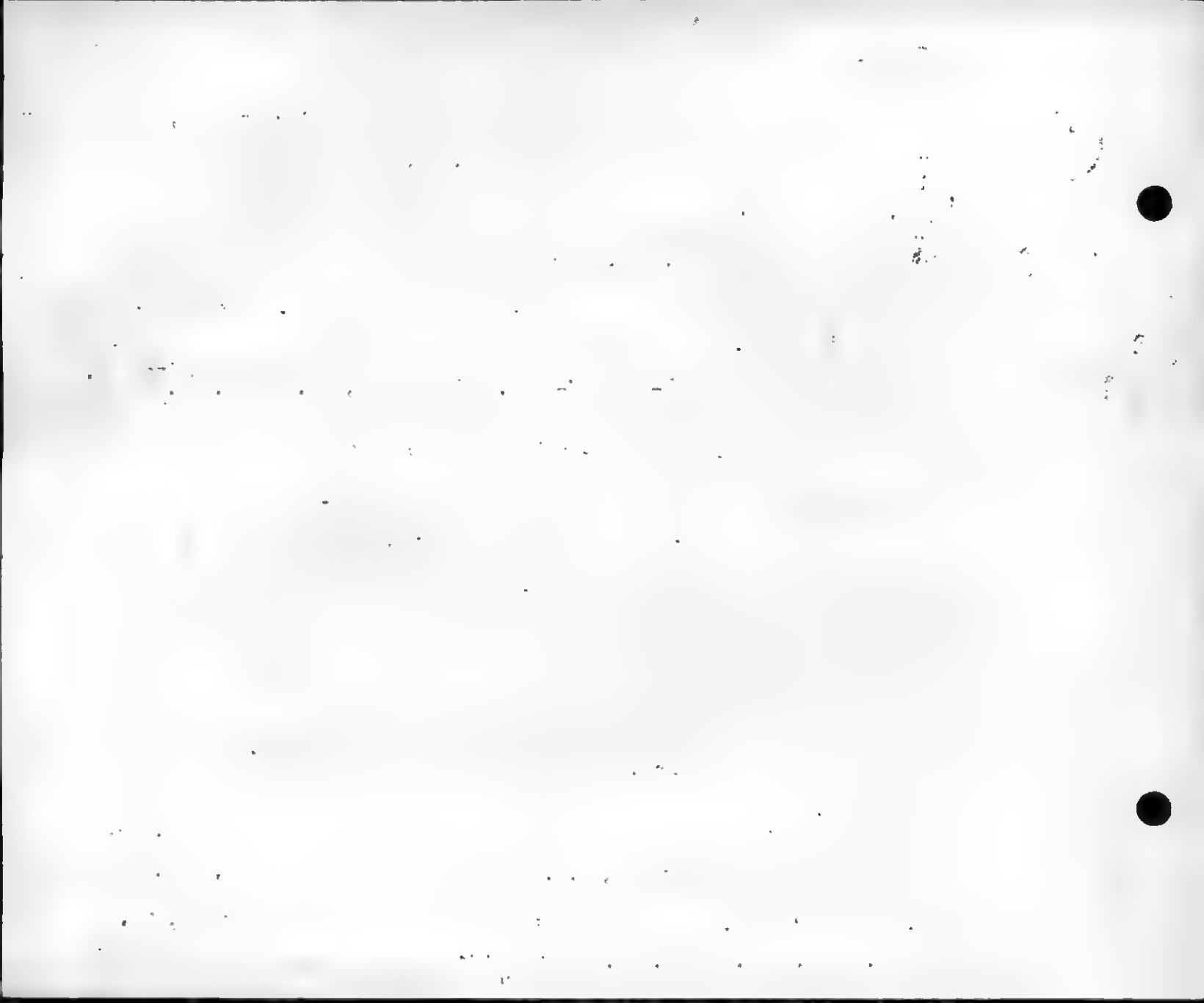


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---|---|--|--|---|--|-----------------------------------|----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| MARY EDNA BOYD | | | | | | November 28, 1968 | | | 6:00AM |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | White | Dec. 14, 1893 | | | | 74 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| Maryland | USA | | | Baltimore | | | Md | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | St. Joseph Hospital | | | Homemaker | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Baltimore | | 5405 Morello Rd. 21214 | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| David E. Dick | | | Marian Thompson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | | | | |
| No | | 217-14-1687-D | | Mr. Walter Boyd, Jr. 8103 Glen Gary Rd. Balto., Md. 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive infarction of small bowel | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) Superior mesenteric vein thrombosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Surgical repair of injured superior mesenteric vein | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| (Hemicolectomy fo carcinoma) | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from November 13, 1968, to Nov. 28, 1968, that (I) (we) last saw the deceased alive on November 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Christiana Feliciano, M.D. | | | | | | | | Nov. 28, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| | | | | 7620 York Road Balto., Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | 12/2/68. | Parkwood Cemetery | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc. Balto., Md. 21214 | | | | | | NOV 29 1968 | | Charles Judge | |

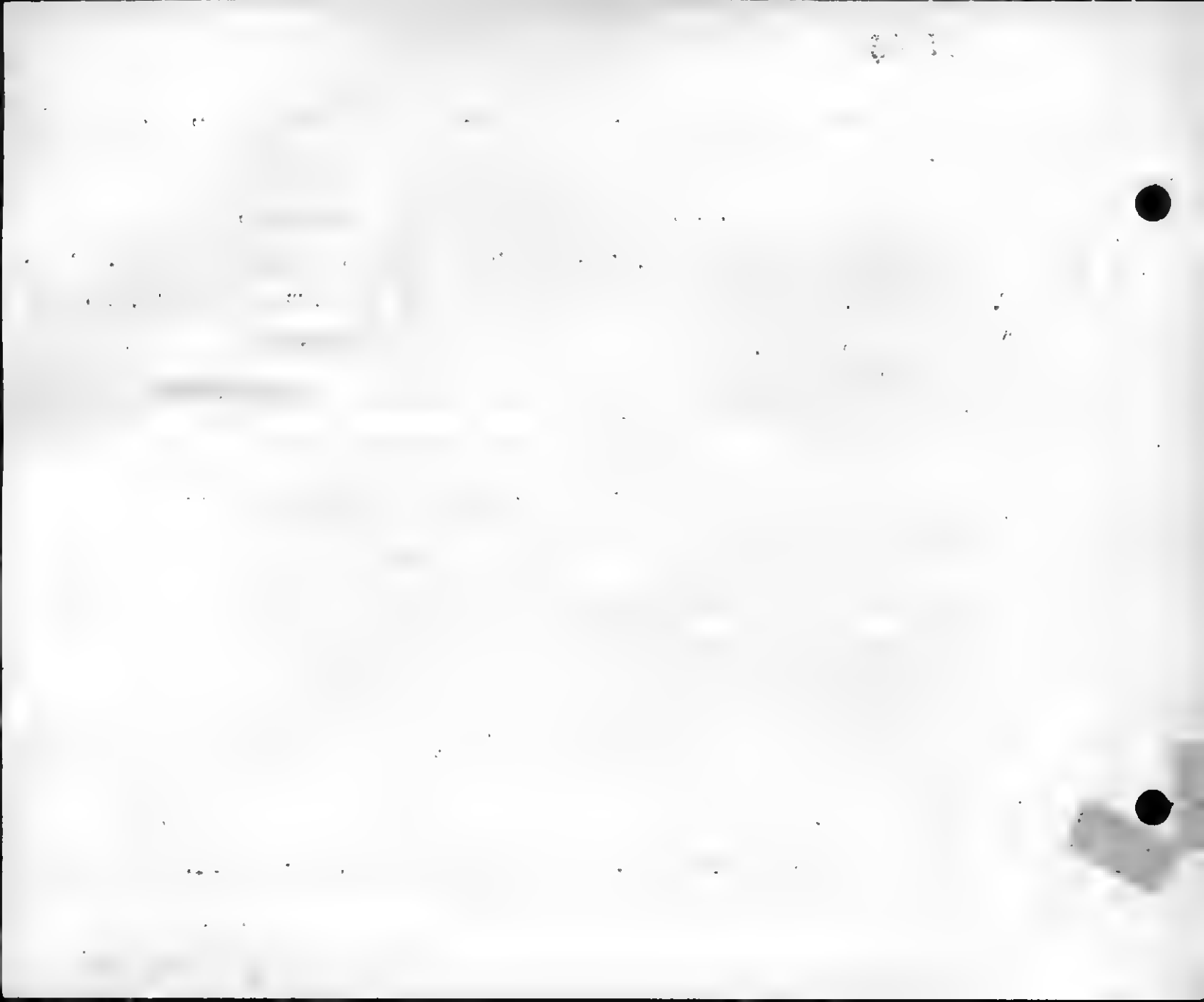


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VA 15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|---|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| WILLIAM | | | JOSEPH | | | NOVEMBER 6, 1968 | | | 5:13 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | |
| Male | | White | | May 3, 1910 | | 58 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md | |
| Baltimore | | U.S.A. | | | | BALTIMORE | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| TOWSON | | | ST. JOSEPH HOSPITAL | | | City of Baltimore | | | DEPT. of PARKS |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. IN-STATE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| STATE MARYLAND | | | — | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3920 LYNDAL AVE. #21213 | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Frank O. Boyle | | | | Mary Shannahan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | |
| yes | | | | Army WW 2 | | Margaret Goldbeck Boyle, wife, above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage | | | | | | | | | |
| 4319 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) left ventricular aneurysm with mural thrombosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 21x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 5 1968</u> to <u>November 6 1968</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>November 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Ines Cilliani</i> | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/9/68 | | Holy Redeemer Cemetery | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | | NOV 12 1968 | | <i>Charles Judge</i> | | | |

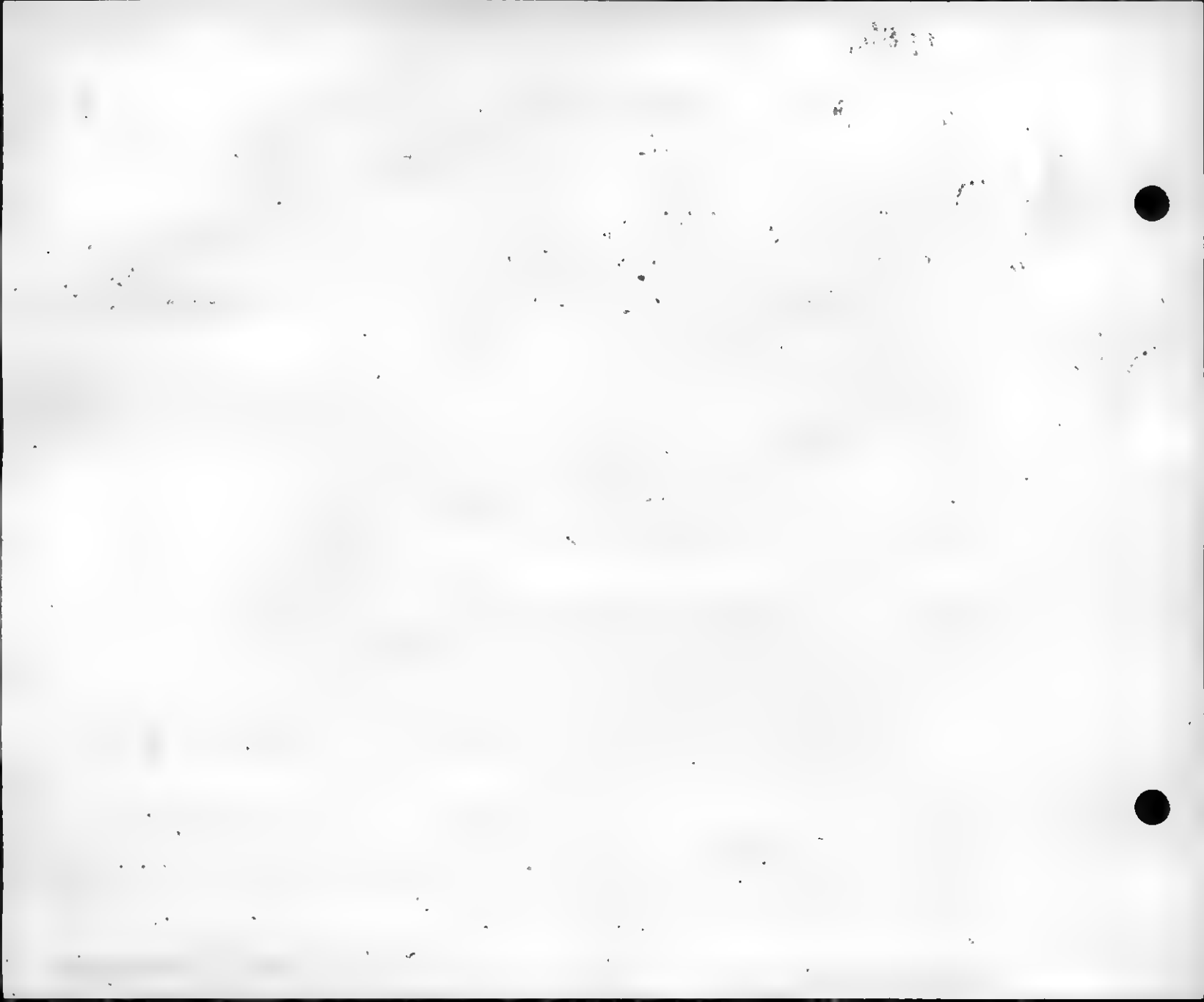


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15
30M REV. 1-64

| 15430 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15492 | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|----------|--|--|--|--|
| 1 DECEASED NAME | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | |
| (Type or print) | | | | | | | | | | Month Day Year | | | | | | | | | | HOUR MIN | | | | |
| First Middle Last ELLEN THERESA BRAUNSCHWEIGER | | | | | | | | | | 11 6 1968 | | | | | | | | | | 7:20 PM | | | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| female | | | white | | | 10-29-1912 | | | 56 YRS. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore Md | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Towson | | | St. Joseph Hospital | | | homemaker | | | HOME | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Res. den. before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | |
| Maryland | | | K | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1625 DARTFORD RD. - 2120 ELLIOT ST. ESSEX, MD | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | |
| WM. H. WHITE, SR. | | | | | ELLEN T. | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | |
| No | | | | | - | | | | | Mr. Wm. H. Braunschweiger - 1623 Dartford Rd. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Congestive heart failure</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>Mitral stenosis</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 410X | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from 11/5/1968, to 11/6/1968, that (A) (we) last saw the deceased alive on 11/6/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Reynaldo Orjuela-Gomez, M.D. | | | | | | | | | | 11/7/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| Reynaldo Orjuela-Gomez, M.D. | | | | | | | | | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | 11-11-68 | | | | | BALTO. NATIONAL CEM. | | | | | BALTO. MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Charles Miller - 2334 | | | | | | | | | | DATE NOV 12 1968 | | | | | J. Charles Judge | | | | | | | | | |



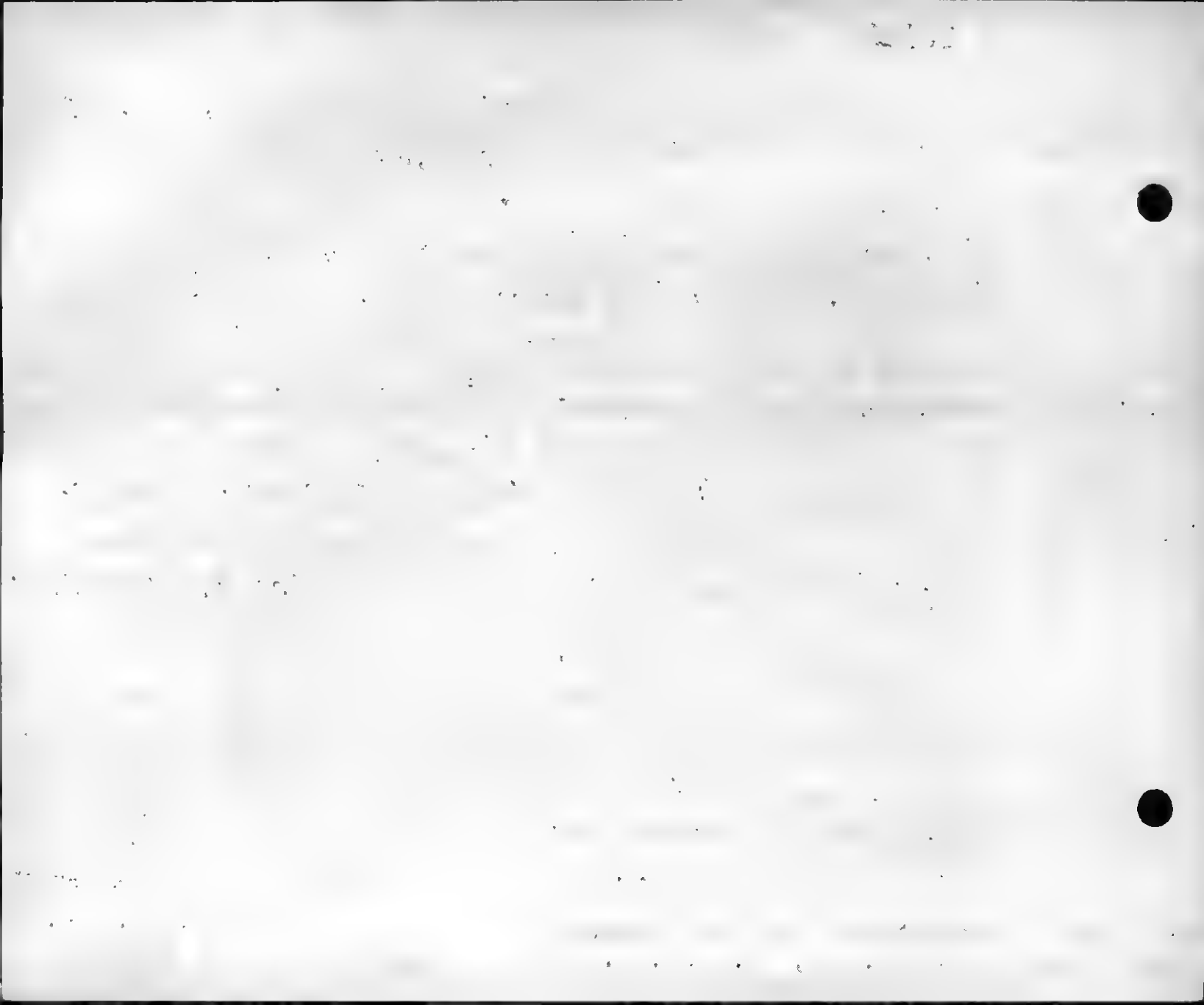
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 1548 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15493 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-------------------------------|--|--|
| 1 DECEASED-NAME (Type, or print) | | | First ELIZABETH | | | Middle BREIDENBAUGH | | | Last | | | 2a. DATE OF DEATH November 6, 1968 | | | 2b. HOUR 2:20 PM | | |
| 3 SEX Female | | | 4 RACE White | | | 5 DATE OF BIRTH July 10, 1881 | | | 6 AGE (In years last birthday) 87 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Glen Arm | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER Glen Arm Md | | | | | |
| 14 FATHER'S NAME James | | | First M | | | Middle Billingsley | | | Last Ida | | | 15. MOTHER'S MAIDEN NAME Ida | | | Middle Baker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT Mr William Breidenbaugh | | | Address Same | | | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>44.3 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u> <u>10 yrs.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral Thrombosis (#2) Pulmonary Tbc. Fractured Hip.</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2 Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/28, 58</u> to <u>11/6, 66</u> , that (I) (we) last saw the deceased alive on <u>11/6, 1966</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Clifford F. Hudson, M.D.</u> | | | 22c. DATE SIGNED 11/7/68 | | | 22d. PHYSICIAN'S NAME (Type) Clifford Hudson M.D. | | | 22e. ADDRESS Fork, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/9/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Wagh Chapel | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md. | | | | | | | | |
| 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | ADDRESS | | | 25a. REC'D BY REGISTRAR NOV 7 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | |

MEDICAL CERTIFICATION



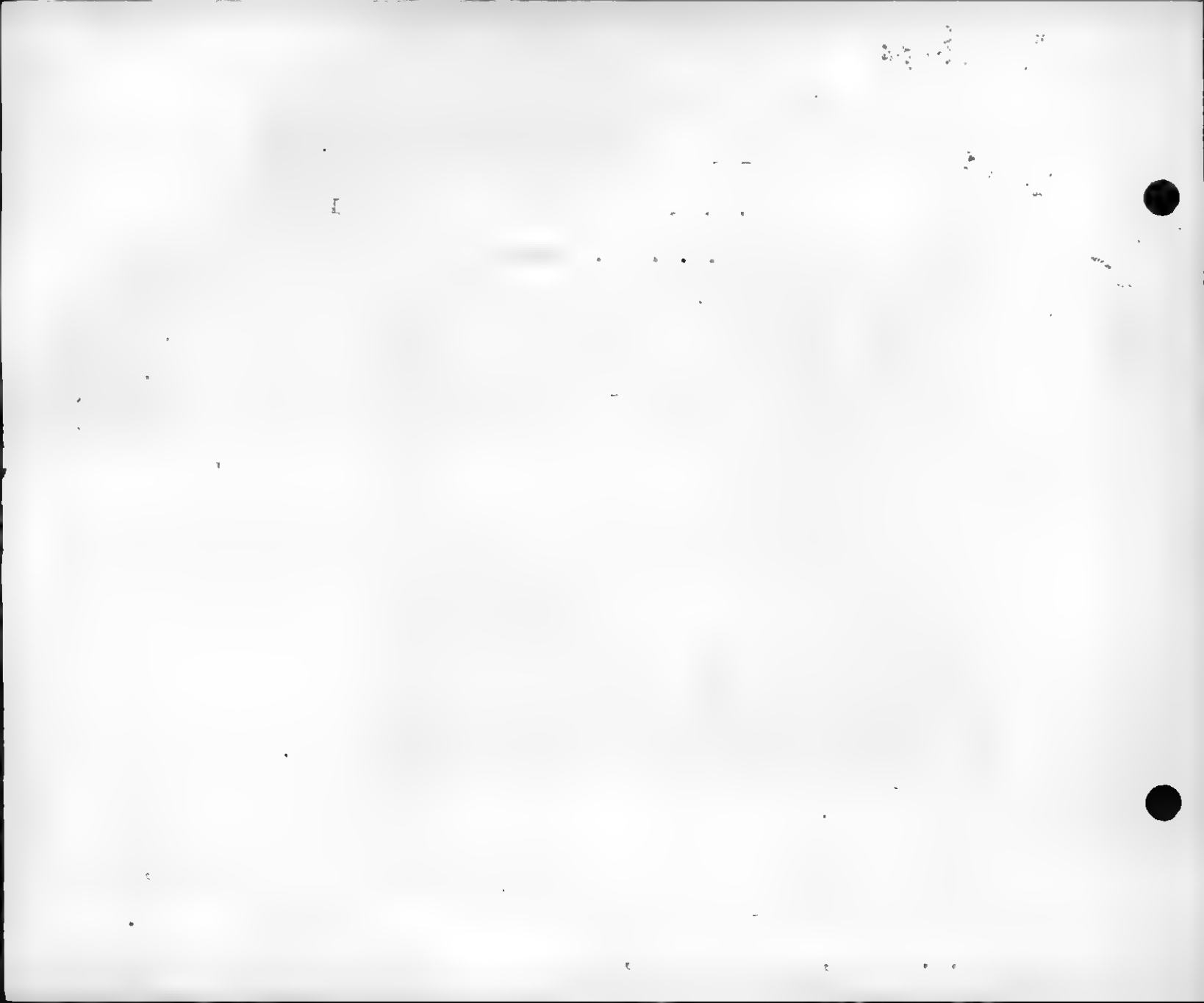
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115ME 15,
10M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|---------|-----------------|---|-----------------|-----------------|---|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| MARITA Elizabeth BROWN | | | | | | Month Day Year | | | November 7 1968 | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| female | Colored | 1-7-1900 | 68 YRS | MONTHS | DAYS | Month Day Year | | | November 7 1968 | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| Md | | | U. S. A. | | | | | | Baltimore Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | D.O.A. St. Josephs Hosp | | | Domestic | | | ***** | | |
| 13a U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | |
| Md | | | **** | | | Baltimore | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | | 16b SOCIAL SECURITY NO | | |
| Charles Henry Stanton | | | Eliza NMN Summers | | | No | | | 216-20-0932 | | |
| 17a | | | 17b | | | 17c | | | 17d | | |
| | | | | | | Roger Brown | | | 3309 Liberty Hgts Ave | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion Sudden | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4 x 01 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| CAUSE OF DEATH | | | P.M. 19 | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town County State | | |
| | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | 11/7/68 | | | | | |
| Charles F. O'Donnell, M.D. | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | Baltimore, Md | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | | 11-11-1968 | | | Fairview | | | Frederick Fred. Md | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| C.E. Hicks, 111 Frederick, Md | | | | | | NOV 12 1968 | | | Charles Judge | | |

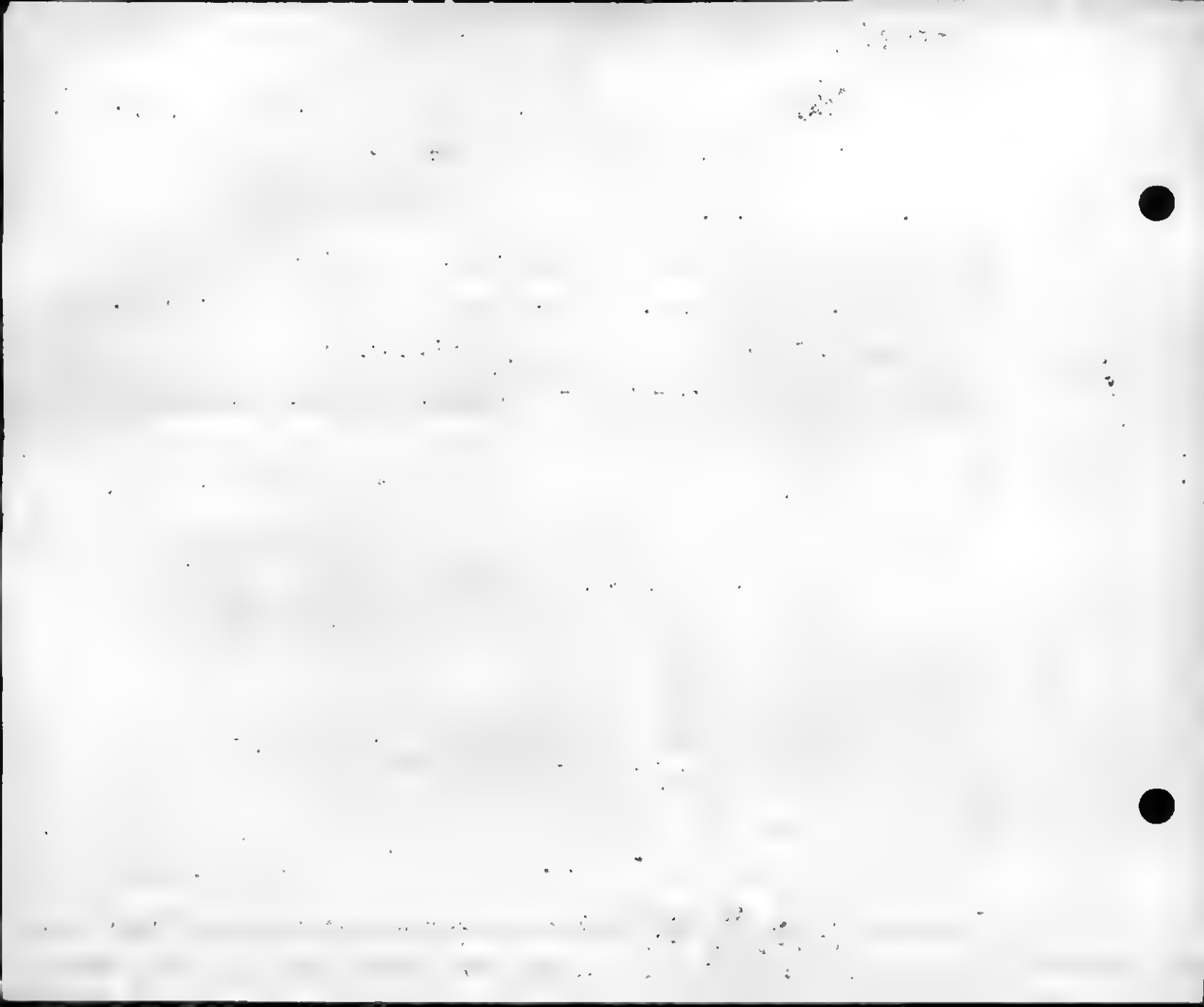


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV 1/68.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Villa | | | Middle Brown | | | Last | | | 2a. DATE OF DEATH Month November Day 27 Year 1968 | | | 2b. HOUR 8:15 M | | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH 1883 JAN. 3, 1881 | | | 6. AGE (In years last birthday) 87 YRS. | | | 7. UNDER YEAR MONTHS 8 DAYS 7 | | | 8. UNDER 24 HRS HOURS 15 MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | 9b. HOUR | | | 9c. MIN | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) school teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 1009 Potomac St. | | | | | |
| 14. FATHER'S NAME First George G. Middle Brown Last | | | 15. MOTHER'S MAIDEN NAME First Mary C. Middle Bussard Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 219-54-3045-JL | | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4120 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Hypertension - Cerebrovascular accident - Uremia | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from April 23 , 19 68 , to Nov. 27 , 19 68 , that (I) we lost saw the deceased alive on Nov. 27 , 19 68 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) did not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Diomidis L. Pirovolidis | | | DEGREE M.D. | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 11-27-68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D. | | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE Nov. 29, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Smithsburg Wash. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Charles M. Baugher | | | ADDRESS Hager Md. | | | 25a. REC'D BY REGISTRAR DEC 2 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |

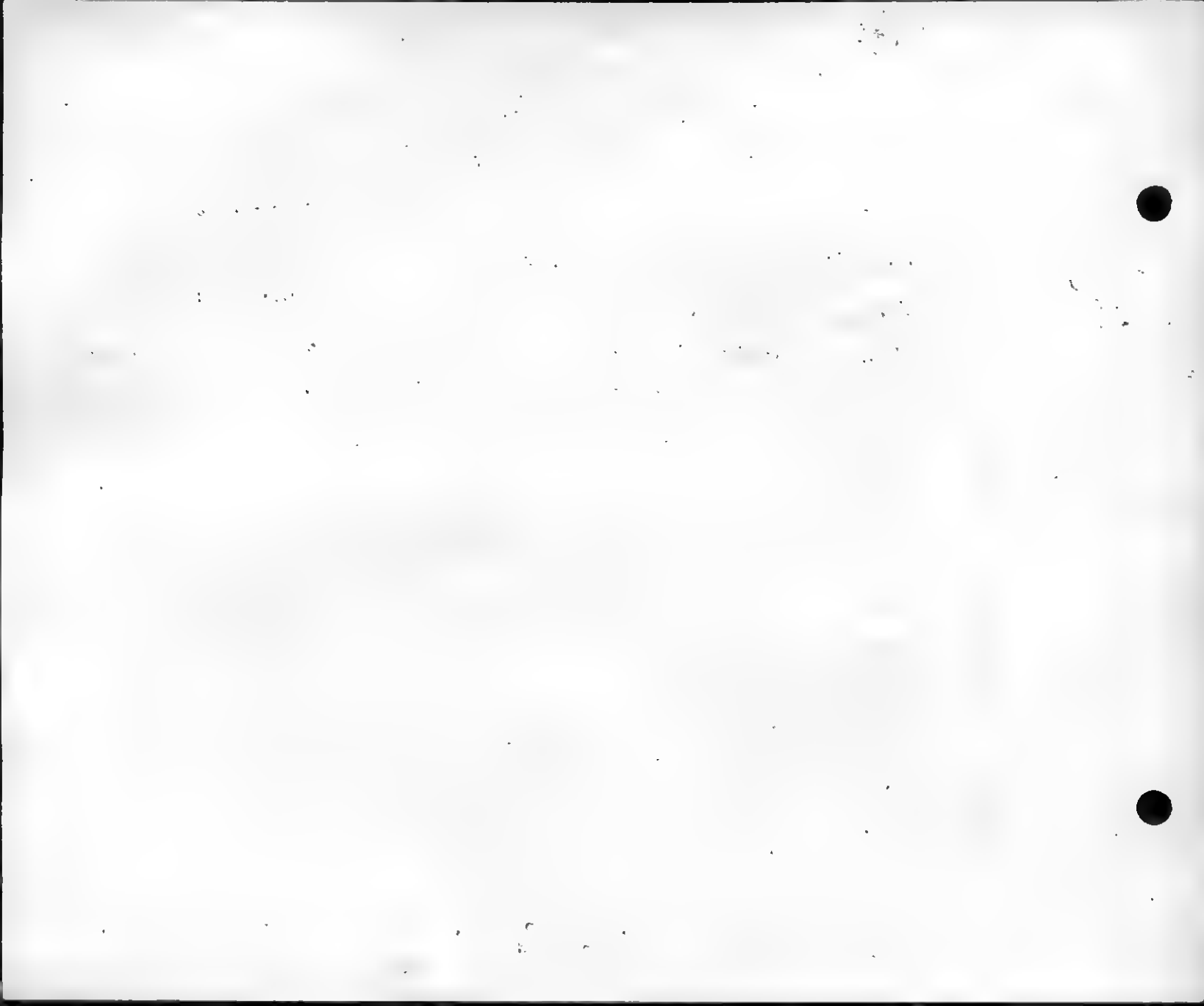


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15484 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15486 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH Item 13c&8, Film G407 12/9/68 </div> | | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) MARY REEVE BRUNS | | | 2a. DATE OF DEATH Month 11 Day 28 Year 68 | | | 2b. HOUR 3:30 A.M. | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 3/23/1892 | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) PENN | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON, MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STELLA MARIS HOSPICE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Sparks | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Dulaney Valley Rd. Box 705 | |
| 14. FATHER'S NAME First Middle Last John Landon Reeve | | | | 15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE CANN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO 217-52-8461 | | 17. INFORMANT Address STELLA MARIS HOSPICE, TOWSON MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-29 , 19 68 , to 11-28 , 19 68 , that (I) (we) last saw the deceased alive on 11-28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-29-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cem. | | 23d. LOCATION (City or Town) (County) (State) Hickory, Harford Co. | | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. 21212 | | | | | 25a. REC'D BY REGISTRAR DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

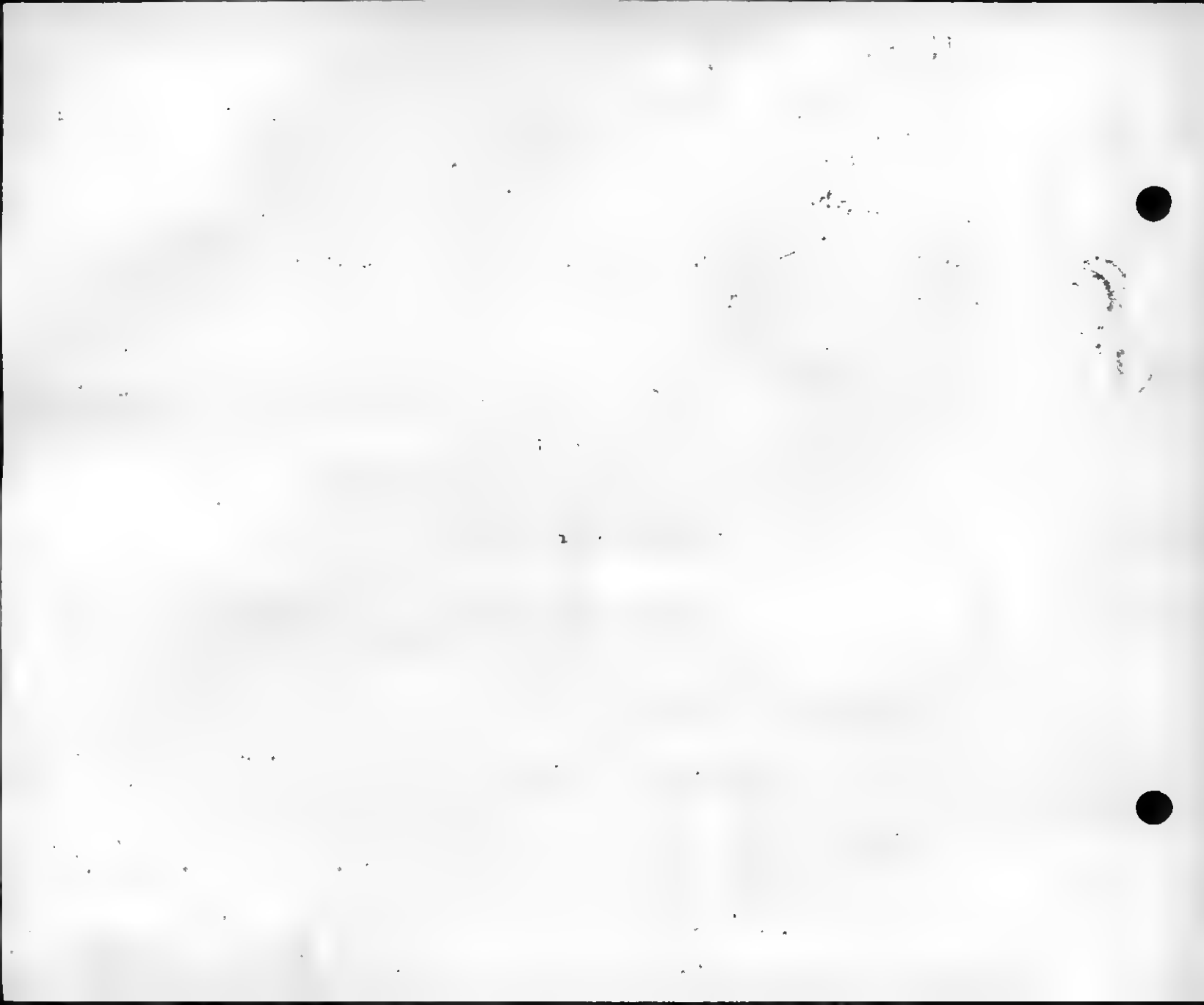


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| 15485 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 13407 | |
|---|--|--|--|--|--|--|--|--|---|---|--|------------------------|--|--|-----------------|--|--|--|--|----------|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | |
| MILDRED AGNES BUEHLER | | | | | | | | | | November 16 1968 | | | | | | | | | | 4:30AM | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | 7. UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | |
| Female | | | White | | | Nov. 24, 1912 | | | 55 YRS. | | | MONTHS | | | DAYS | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Maryland | | | USA | | | | | | Baltimore Md. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Towson | | | St. Joseph's Hospital | | | Homemaker | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIM 15? | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | Baltimore | | | Baltimore | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 714 Murdock Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | |
| Lawrence F. Appel | | | | | Katherine E. Peterson | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17 INFORMANT Address | | | | | | | | | | | |
| No | | | | | 212-07-2859 | | | | | Mr. Christian Buehler (Same, | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3940</u> Congestive heart failure | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>mitral stenosis and insufficiency</u> | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>rheumatic heart disease</u> | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 3 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from Nov. 13, 1968, to Nov. 16, 1968, that (b) (we) last saw the deceased alive on Nov. 16, 1968, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Christina Feliciano, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED Nov. 16, 1968 | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D. 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | | | | | | | | | | | | |
| 23b. DATE 11/19/68. | | | | | | | | | | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | | | | | | | | | | | | | | | | | | | | |
| 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balt. Md 21214 | | | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | | | | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | | | | | | | | | | | | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

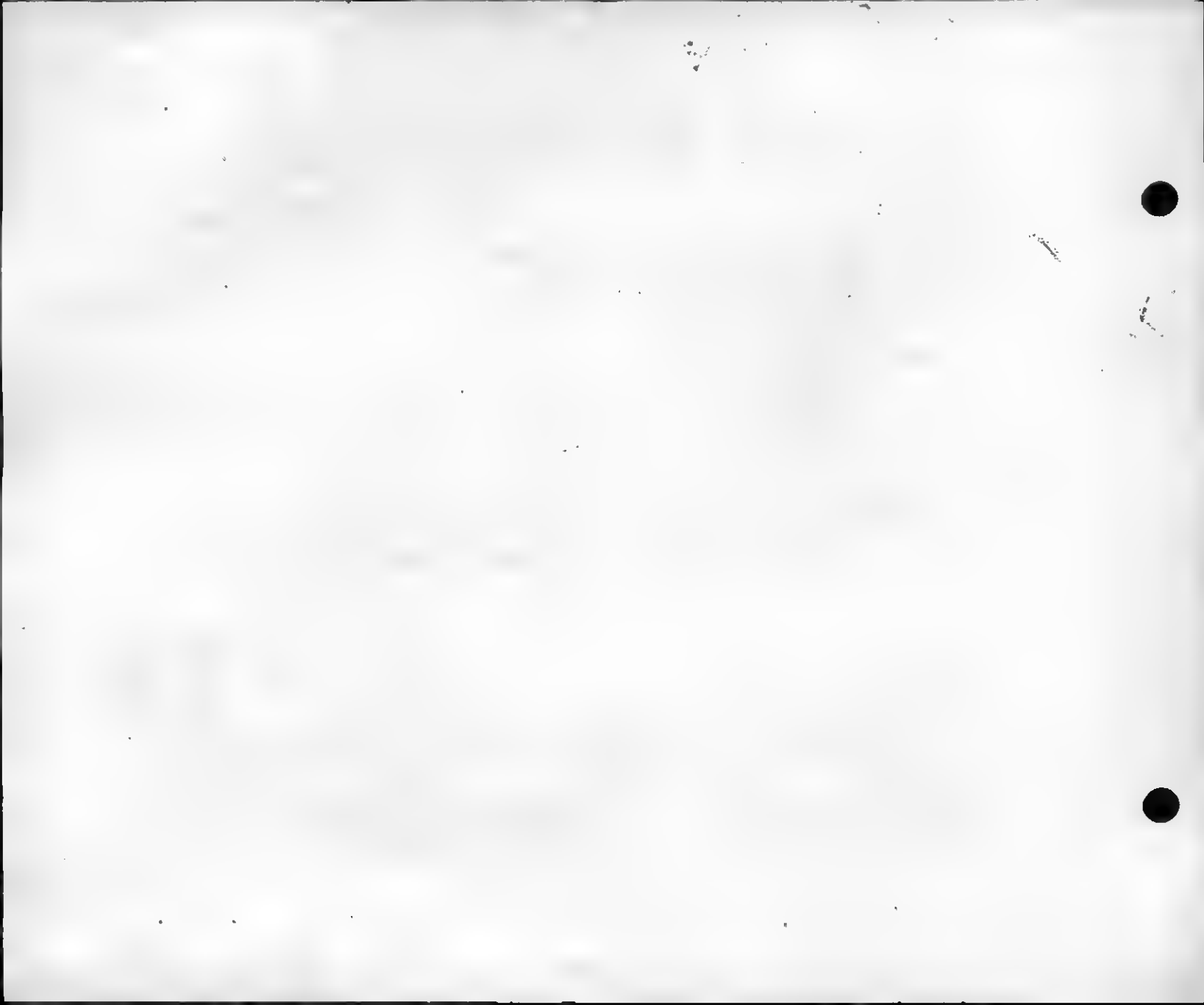
15488

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15488

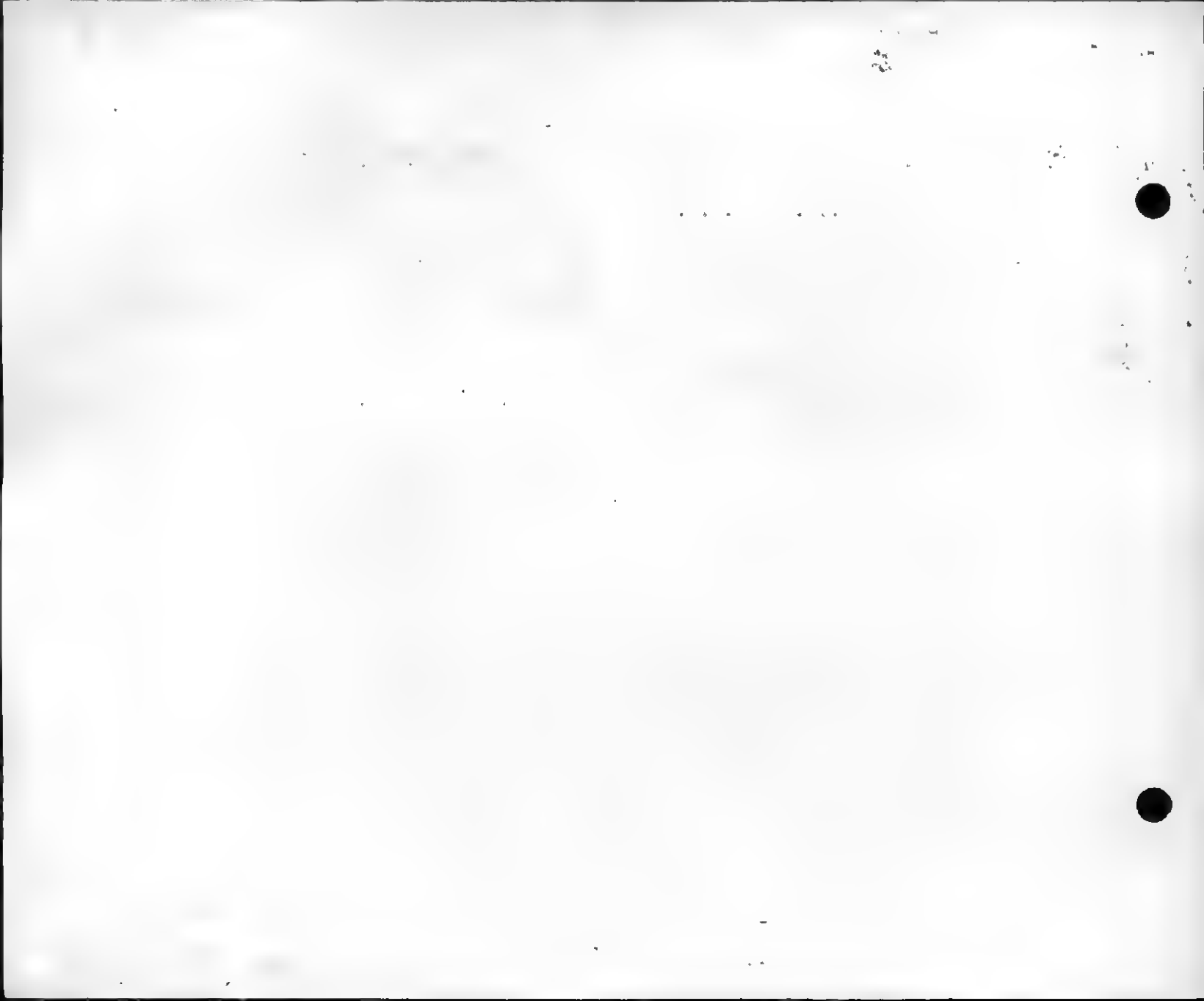
| | | | | | | | | | | | | |
|--|------------------------|--|---|--|--------------------------------------|---|--|---|--|--|--|--|
| 1 DECEASED NAME (Type or Print) <i>Mary Emily Bull</i> | | | First Middle Last | | | 2a DATE KNOWN OF ESTI- DEATH MATED <i>Nov. 29, 1968</i> | | | 2b HOUR M | | | |
| 3 SEX <i>Female</i> | 4 RACE <i>White</i> | 5 DATE OF BIRTH <i>Mar. 4, 1888</i> | 6 AGE (In years last birthday) <i>80</i> YRS | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD Month <i>Nov.</i> Day <i>29</i> Year <i>1968</i> | | | 2d HOUR M | |
| 7a BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | |
| 10 CITY OR TOWN OF DEATH <i>Cockeysville</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hollow Road</i> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i> | | | 13b COUNTY <i>Baltimore</i> | | 13c CITY OR TOWN <i>Cockeysville</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER <i>Hollow Road</i> | | | |
| 14 FATHER'S NAME <i>Samuel Sheeler</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME <i>Alice F. Sheeler</i> | | | First Middle Last | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16b SOCIAL SECURITY NO. <i>None</i> | | | 17. INFORMANT <i>Family records</i> | | | ADDRESS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i> <i>4107</i> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7201</i> | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | 21f LOCATION Street or R.F.D. No. | | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>William F. Fisher</i> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b DATE <i>Dec. 2, 1968</i> | | | 23c NAME OF CEMETERY OR CREMATORY <i>Boplar Grove Cemetery</i> | | | 23d LOCATION (City or Town) (County) (State) <i>Cockeysville, Md.</i> | | | |
| 24 FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i> | | | | | | 25a REC'D BY REGISTRAR <i>DEC 4 1968</i> | | | 25b REGISTRAR'S SIGNATURE <i>William F. Fisher</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) Ida | | | First Middle Last Burke | | | 2a. DATE OF DEATH Month November Day 24 Year 1968 | | | 2b. HOUR 7:30 PM | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH XXXXXXXXXXXXXX | | | 6. AGE (In years last birthday) 71 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) XXXXBALTO. MD. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH XXXXXXXXXXXX BALTIMORE Md | | |
| 10. CITY OR TOWN OF DEATH GARRISON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Noxleigh Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | | 13b. COUNTY --- | | | 13c. CITY OR TOWN BALTIMORE | | | 13e. STREET AND NUMBER 3605 FERNHILL AVENUE #15 | | |
| 14. FATHER'S NAME First SAMUEL Middle TUCKER Last --- | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle --- Last FREEMAN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 261-46-0818 | | |
| 17. INFORMANT MRS. RUTH HECHT | | | Address 3605 FERNHILL AVENUE #21215 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septicemia | | | DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis | | | DUE TO, OR AS A CONSEQUENCE OF (c) --- | | | Days | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369 | | | | | | | | | Years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Vascular Accident Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. ALTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-1 , 1967 to 11-24 , 1968, that (I) (we) last saw the deceased alive on 11-24 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE David J. Miller | | | DEGREE --- ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 11/24/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) David J. Miller | | | 22e. ADDRESS 9115 Reisterstown Rd. | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | | 23b. DATE 11-26-68 | | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH BETH ISRAEL | | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | ADDRESS --- | | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |



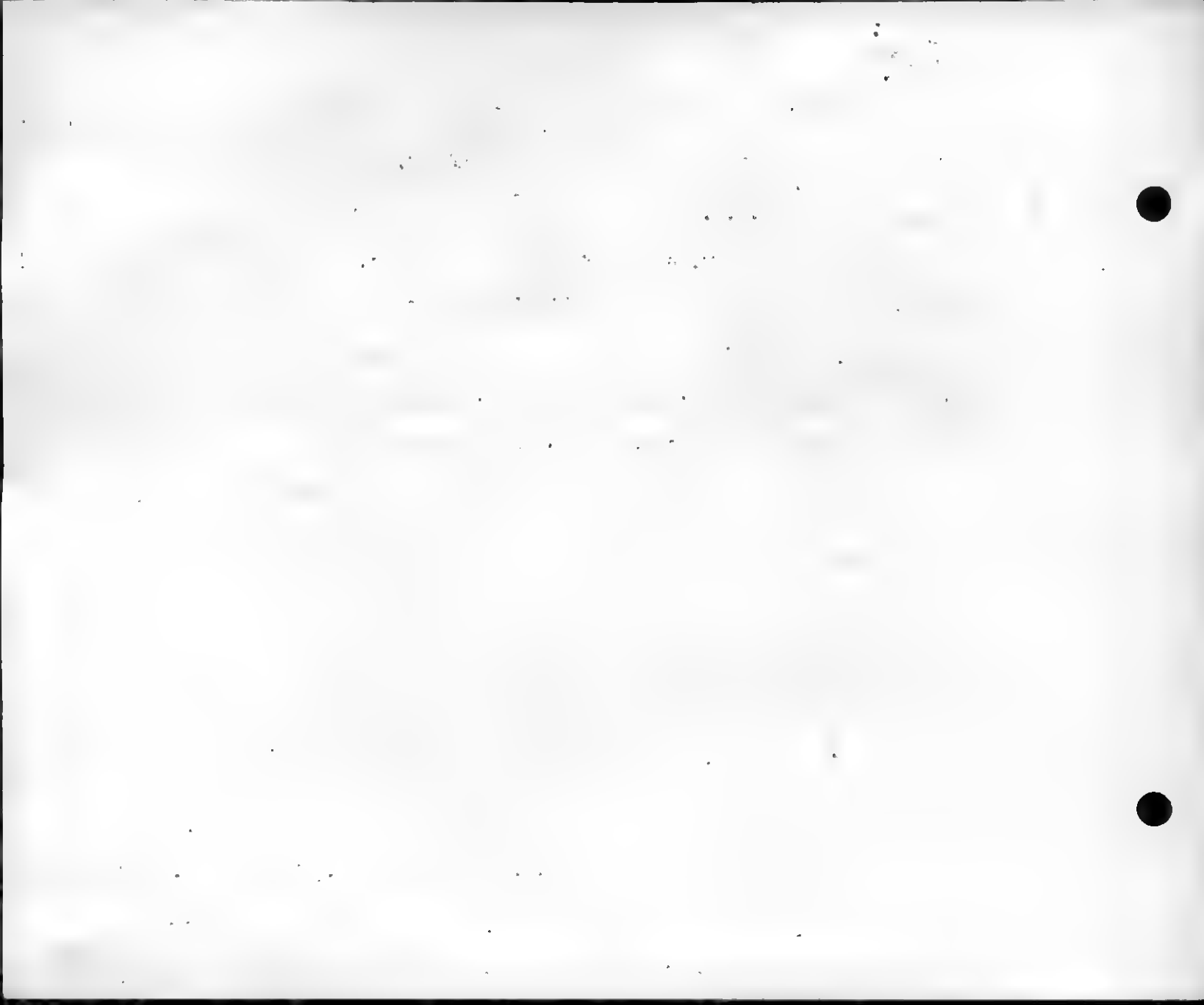
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15500 |
|--|--|--|--------------------|---|---|---|---|---|------------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First James | Middle P | Last Burke | 2a. DATE OF DEATH Month 11 Day 6 Year 1968 | | | 2b. HOUR 7 A.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH March 14, 1896 | | 6. AGE (n years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, | | | Md | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Assist Store Keeper Gas & Ele | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3724 Yolando Rd. | | |
| 14. FATHER'S NAME First Middle Last John F Burke | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret Keavney | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1 | | 16b. SOCIAL SECURITY NO. 212-05-6442 | | 17. INFORMANT Mrs Genevieve Burke | | | Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent antero-lateral myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that A (this hospital) attended the deceased from 10/31/ , 19 68 , to 11/6/ , 19 68 , that A (we) last saw the deceased alive on 11/6/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Reynaldo Orjuel Ya-Gomez, M.D. | | | | | DEGREE M.D. | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuel Ya-Gomez, M.D. | | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Md. | | | | | 25a. REC'D BY REGISTRAR DATE NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATE ON

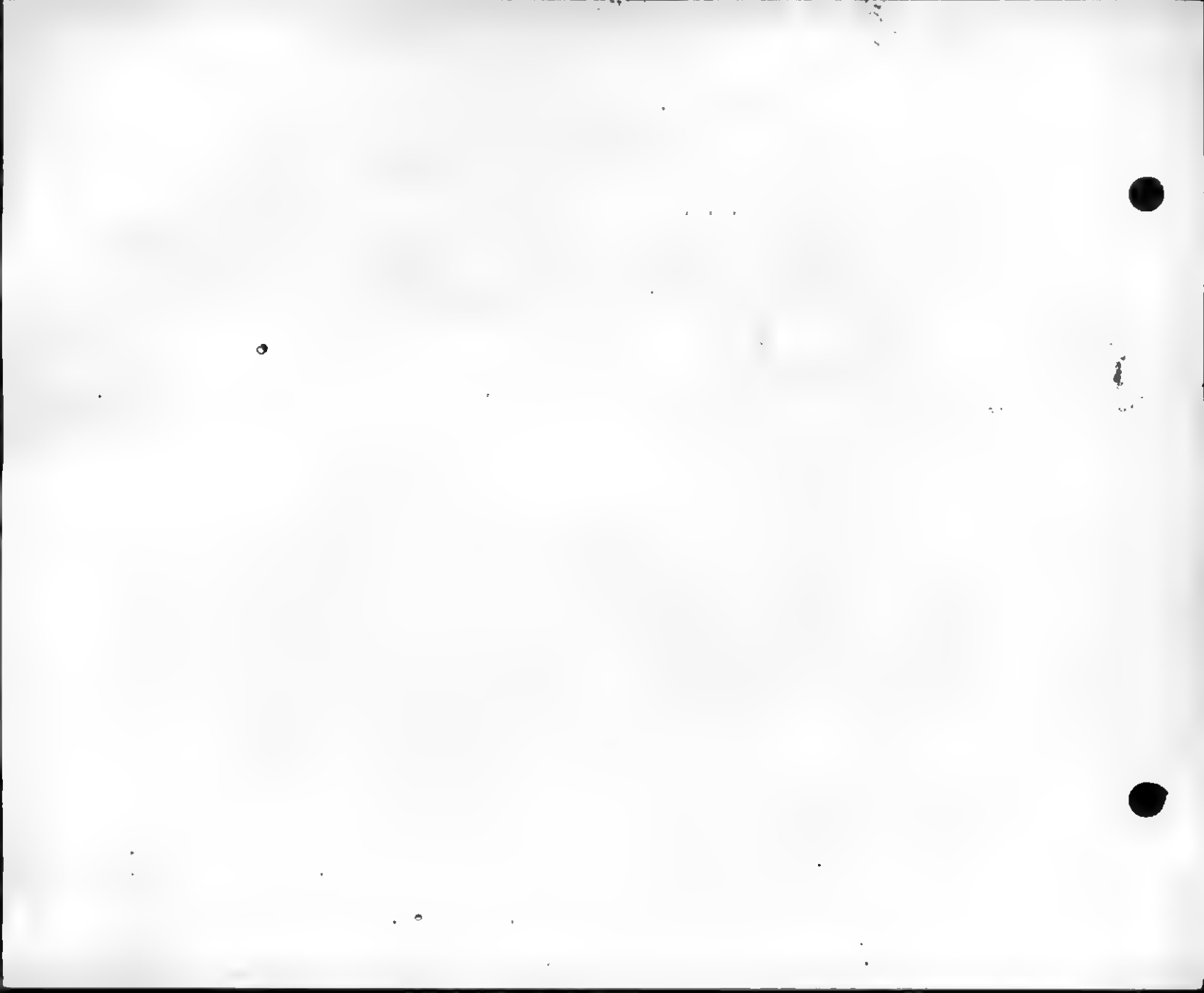


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

| 15489 - | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15501 | |
|---|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|----------|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | |
| First Middle Last CATHERINE C. BURLEY | | | | | | | | | | Month Day Year November 28, 1968 | | | | | | | | | | M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | 7. IF UNDER 1 YEAR | | | 8. IF UNDER 24 HRS | | | | | | |
| Female | | | White | | | March 23, 1882 | | | 86 YRS | | | MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore Md | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Catonsville | | | House in the Pines | | | Retired Seamstress | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | Baltimore | | | Catonsville | | | | | | 9 Winters Lane | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | |
| Andrew Maisel | | | | | Elizabeth Schaub | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17. INFORMANT Address | | | | | | | | | | | |
| No | | | | | 212-20-9530 | | | | | Mrs. Miriam Ochs, 72 Jumpers Hole Rd. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A. S. C. V. D.</u> | | | | | | | | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Moreland, 1967</u> , to <u>Moreland, 1968</u> , that (I) (we) last saw the deceased alive on <u>11-27-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Barbu Calin</u> | | | | | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c. DATE SIGNED <u>11-29-68</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Barbu Calin</u> | | | | | | | | | | 22e. ADDRESS <u>Md. 21043 21 South St., Johns Lake, Ellicott City</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| BURIAL | | | | | 11-30-1968 | | | | | Moreland Mem. Park Cem. | | | | | Baltimore County, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | | | | | DATE DEC 2 1968 | | | | | <u>Charles Judge</u> | | | | | | |

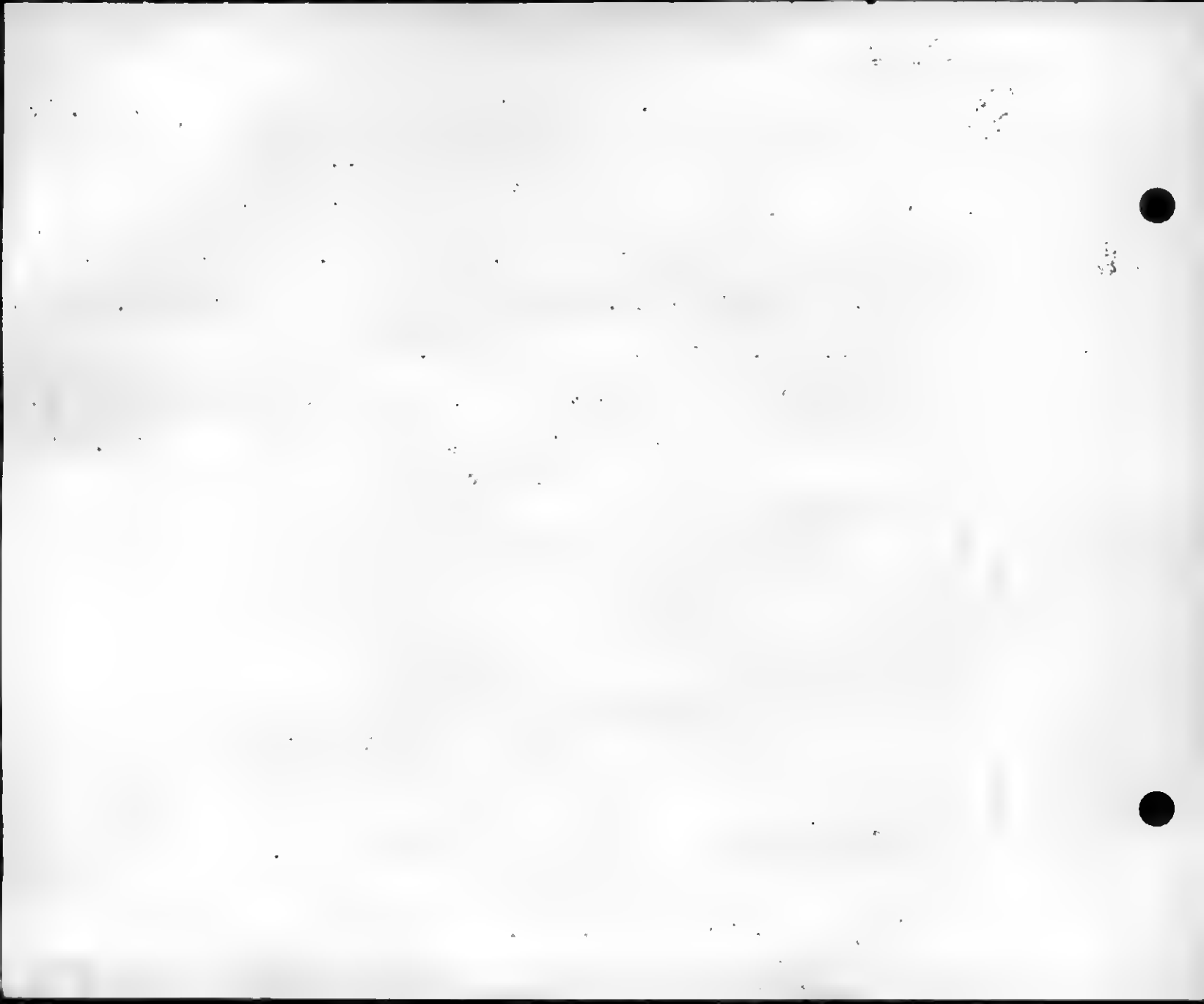


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-15-68
30M REV. 68

| <div style="display: flex; justify-content: space-between;"> 15490 MARYLAND STATE DEPARTMENT OF HEALTH 15562 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) WILLIAM E. BUSHNELL | | | | 2a. DATE OF DEATH Month NOVEMBER Day 29 Year 1968 | | | | 2b. HOUR 11:10 PM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH February 16, 1920 | | | | 6. AGE (In years last birthday) 48 YRS | | 7. UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 311 Roanoke Dr. | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Prof. Engineer | | | 12b. KIND OF BUSINESS OR INDUSTRY Eng. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Kd. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 311 Roanoke Dr. | | | |
| 14. FATHER'S NAME First Frank E. Middle Bushnell Last | | | | 15. MOTHER'S MAIDEN NAME First Harriett Middle McCormick Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes (If yes give war or dates of service) WW II | | 16b. SOCIAL SECURITY NO 489-16-0228 | | 17. INFORMANT Address 311 Roanoke Dr. Mrs Margaret D. Bushnell | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 157.9 IMMEDIATE CAUSE (a) Carcinoma of Pancreas E. General DUE TO, OR AS A CONSEQUENCE OF Mitadeses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____ | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15 , 19 60 , to 11/29 , 19 60 , that (I) (we) last saw the deceased alive on 11/29 , 19 60 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edith Johnson M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/30/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS 3432 Frederick Ave. Baltimore Md 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec 2, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Enterling Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228 | | | | | | 25a. REC'D BY REGISTRAR DEC 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 15492 | | 15503 | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| CORINNE | | G. | | BYER | | November | | Day 16 Year 1968 6:07 P.M. | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | July 25, 1887 | | 81 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | U.S.A. | | | | Baltimore | | Md. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Dundalk | | 6800 Morningside Road | | At home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Baltimore | | Edgemere | | | | 2927 Sparrows Point Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Henry Mann | | Mary Brandau | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | | Henry L. Byer, 3018 Liberty Parkway | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | |
| 1550 | | Carcinoma of Caecum | | Carcinoma of Caecum | | Carcinoma of Caecum | | Carcinoma of Caecum | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | DUE TO, OR AS A CONSEQUENCE OF (c) | |
| | | METASTASIS | | | | | | 22 mos | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| JAN-5-67 | | CA. of Caecum | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Nov 16, 1968, that (I) (we) last saw the deceased alive on Nov 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Nov 16, 1968, that (I) (we) last saw the deceased alive on Nov 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Nov 16, 1968, that (I) (we) last saw the deceased alive on Nov 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Nov 16, 1968, that (I) (we) last saw the deceased alive on Nov 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Nov 16, 1968, that (I) (we) last saw the deceased alive on Nov 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 22e. DATE SIGNED | | 22f. DATE SIGNED | |
| M.B. Davis | | M.B. Davis, M.D. | | 6800 Morningside Road | | 11/18/68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. LOCATION (City or Town) (County) (State) | |
| Burial | | Nov. 19, 1968 | | Parkwood Cemetery | | Parkville, Md. | | | |
| 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | |
| Ullrich Funeral Home Dundalk, Md. | | Ullrich Funeral Home Dundalk, Md. | | Ullrich Funeral Home Dundalk, Md. | | Ullrich Funeral Home Dundalk, Md. | | Ullrich Funeral Home Dundalk, Md. | |
| 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | | 25e. REGISTRAR'S SIGNATURE | |
| DATE NOV 26 1968 | | Charles Judge | | Charles Judge | | Charles Judge | | Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

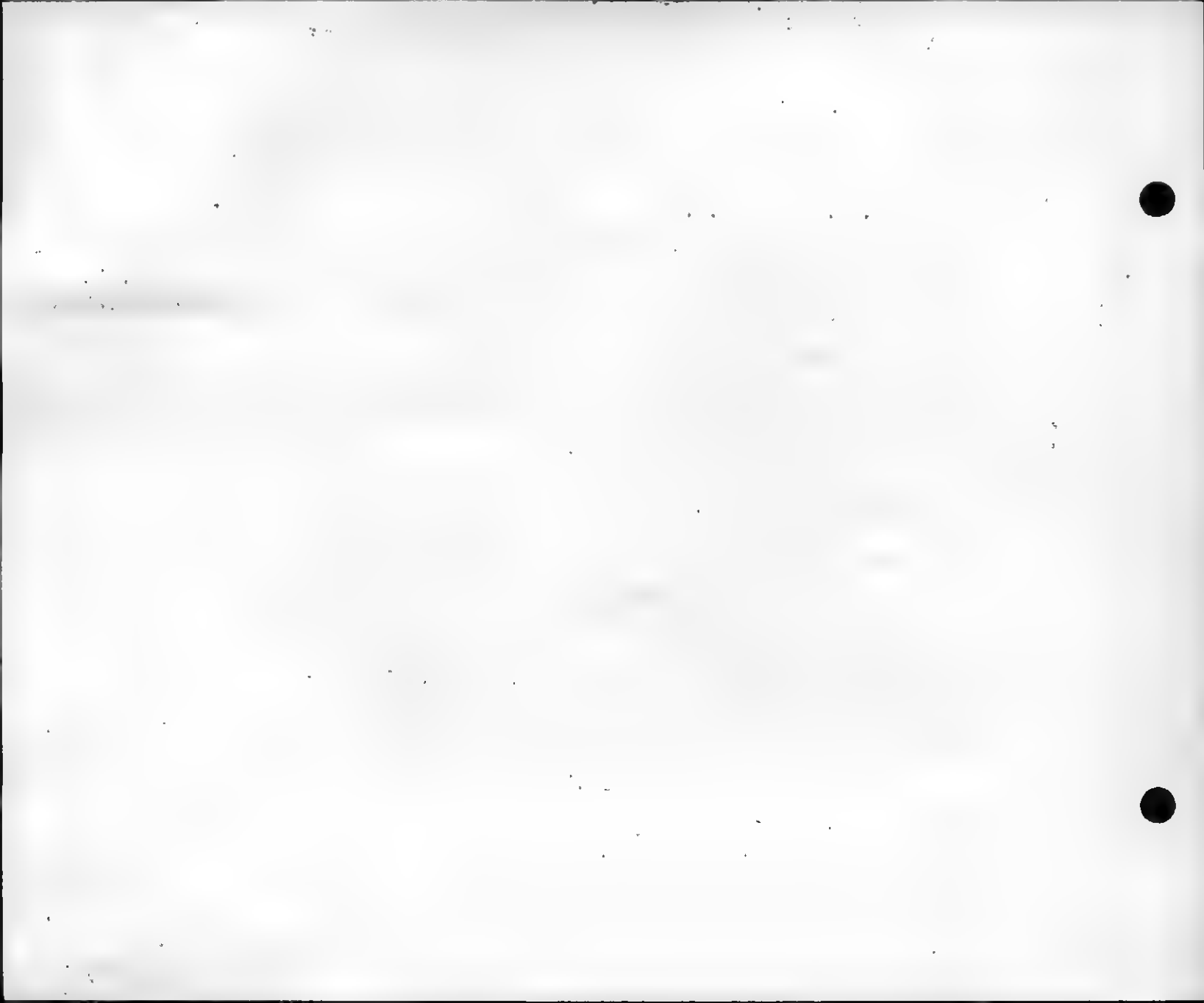
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15492

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1350.

| | | | | | | | | | |
|---|--------------|--|---|--|---|--|---|---|--|
| 1 DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11/10/68 19 | | | 2b HOUR 3:35 p.m. |
| EDWARD | | | CARL | | | BYER | | | |
| 3 SEX male | 4 RACE white | 5 DATE OF BIRTH 10-10-1907 | 6 AGE (in years last birthday) 61 YRS | IF UNDER 1 YEAR MONTHS DAYS | | F UNDER 24 HRS HOURS MIN. | | 2c DATE PRONOUNCED DEAD Month November Day 10, Year 1968 | 2d HOUR 4:20 p.m. |
| 7a BIRTHPLACE (State or foreign country) Balto. Co. Md. | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md. | | |
| 10 CITY OR TOWN OF DEATH Kingsville | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 476 Route 1 | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | | | 12b KIND OF BUSINESS OR INDUSTRY Own farm |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Kingsville | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER Mt. Vista Box 268 Belair Road | | |
| 14 FATHER'S NAME First John Middle Godfried Last Byer | | | 15 MOTHER'S MAIDEN NAME First Rose Middle Snyder Last Snyder | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b SOCIAL SECURITY NO 217-48-3580 | | 17. INFORMANT ADDRESS 21087 Rosalene Zimmerer Box 268 Kingsville Md | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia by Bolus 911X DUE TO, OR AS A CONSEQUENCE OF Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9210 | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CASE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. UNKN 11/10/68 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) asphyxiated by food | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home | | 21f LOCATION Street or R.F.D. No City or Town Baltimore, Md. State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED 11/11/68 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE 11-13-1968 | | 23c NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery | | 23d LOCATION (City or Town) (County) (State) Fork Baltimore Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road 21236 | | | | | 25a REC'D BY REGISTRAR DATE NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

15493

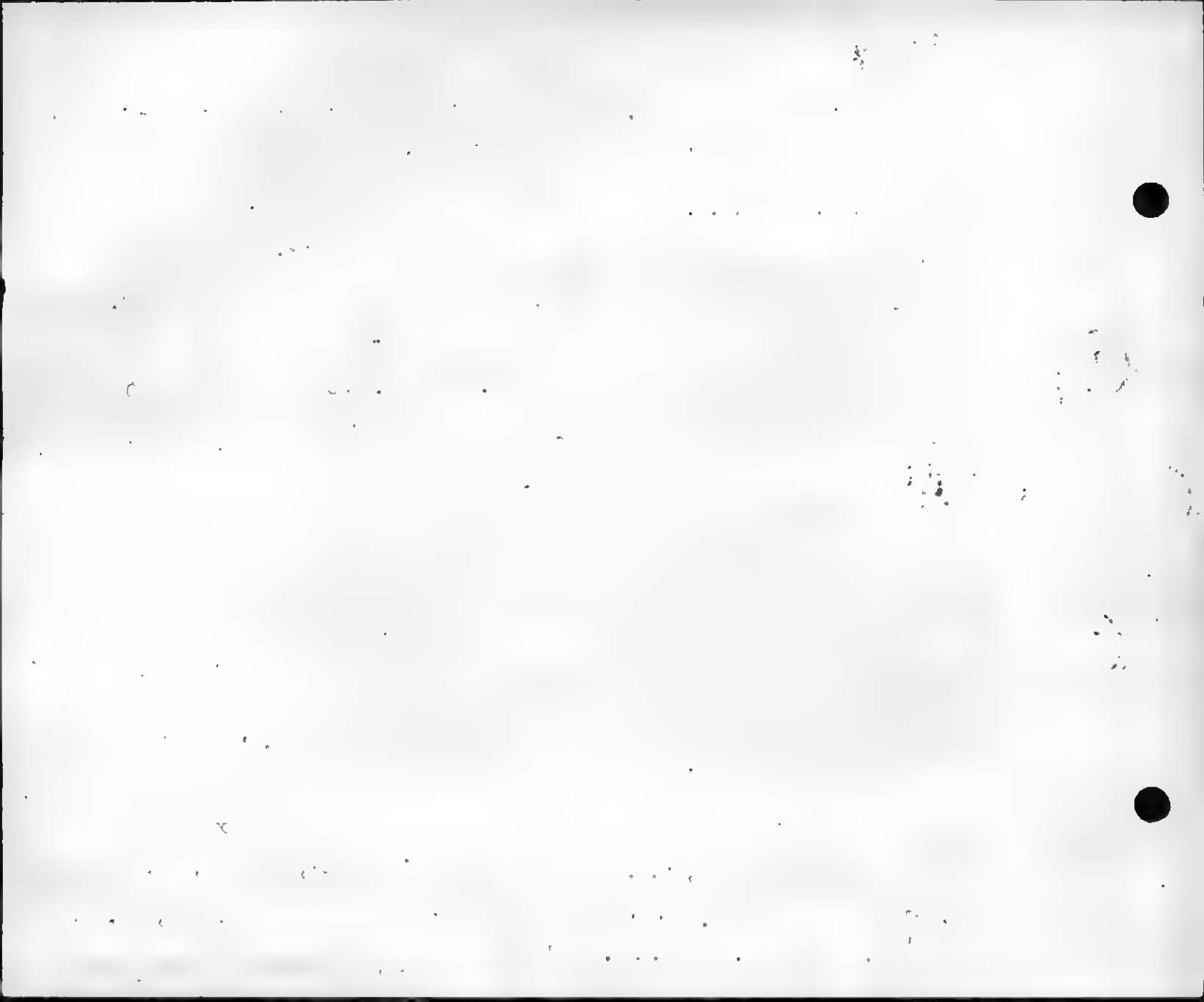
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1550

CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------|--|---|---|---------------------------------|
| 1. DECEASED-NAME (Type or print) JOSEPHINE M. CAMPANARO | | | 2a. DATE OF DEATH Month November Day 15 Year 1968 | | 2b. HOUR 7:20 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH July 28, 1891 | | 6. AGE (In years last birthday) 77 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Baltimore | | 10. CITY OR TOWN OF DEATH Towson | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 13d. INSIDE CITY LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1804 Burnwood Rd. 21214 | | | |
| 14. FATHER'S NAME First Anthony Middle Donna Last Corsa | | | 15. MOTHER'S MAIDEN NAME First Mario Middle Corsa Last Corsa | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Marie C. Maco (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CECUM 1550 DUE TO, OR AS A CONSEQUENCE OF (b) METASTASES TO LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 30, 1968 , to Nov. 15, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 15, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Antonio DeLeon M.D. | | | | 22c. DATE SIGNED 11-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) Antonio DeLeon, M.D. | | | | 22e. ADDRESS 7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/19/68. | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |
| 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

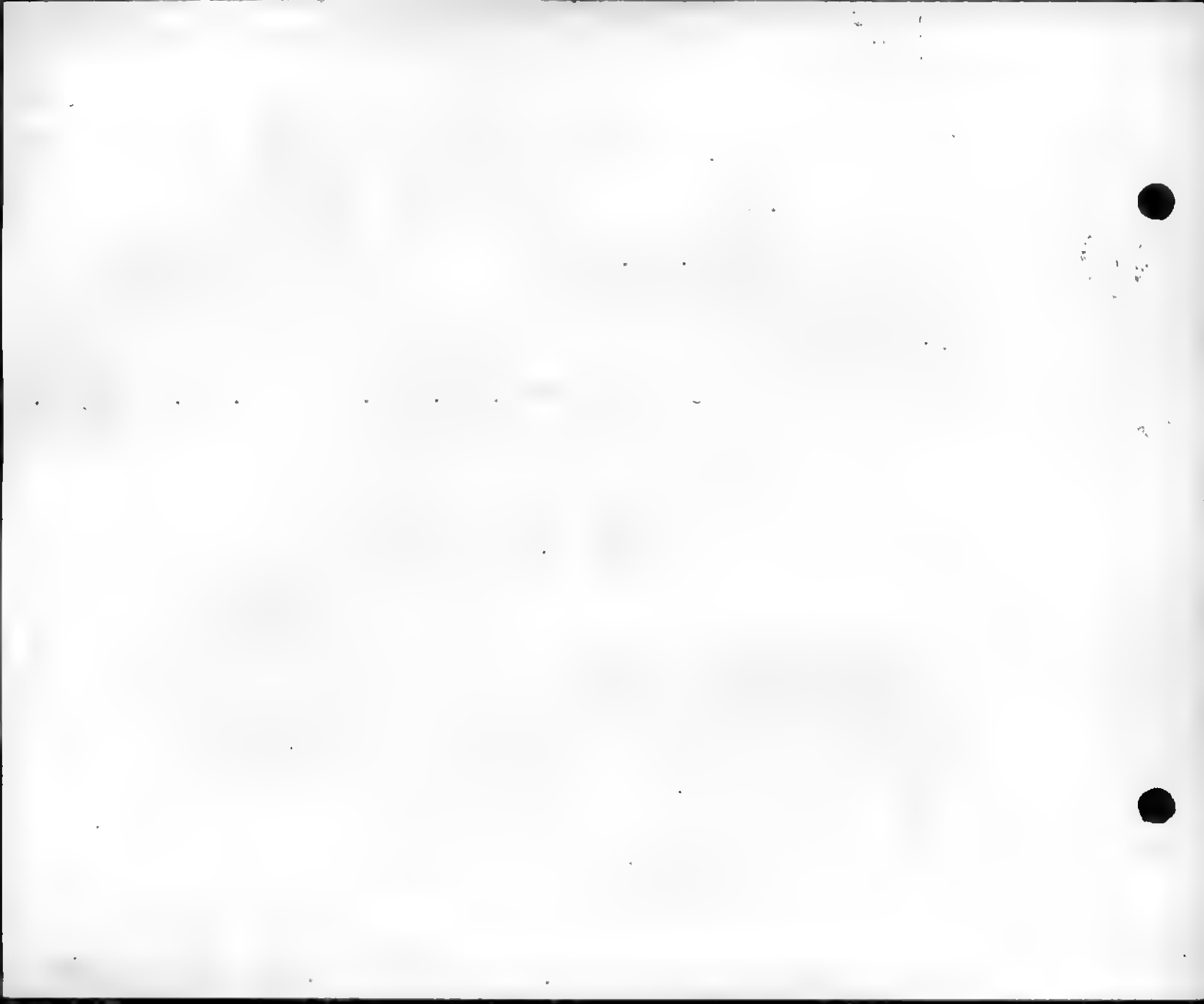
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH Month Day Year | | 2b HOUR 3:30 PM |
| FRANK | | -- | | CANDAMIL | | NOVEMBER | | 25, 1968 | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH JULY 5, 1905 | | 6 AGE (In years lost birthday) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) SPAIN | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH BALTIMORE | | | | MD |
| 10 CITY OR TOWN OF DEATH FORT HOWARD | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL | | | | 12a OCCUPATION (Kind of work done during most of working life, even if retired) FOREMAN | | 12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | |
| 13a USUAL RESIDENCE (Where deceased lived, if admission) STATE MARYLAND | | 13b COUNTY PRINCE GEORGE | | 13c CITY OR TOWN COLLEGE PARK | | 13d INS DE CITY, LIM TST? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 9207 51st AVENUE | | |
| 14 FATHER'S NAME First Middle Last JOSE CANDAMIL | | | | 15 MOTHER'S M A DEN NAME First Middle Last MARIA ANTONIA PINON | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES | | 16b SOCIAL SECURITY NO (If yes give year or dates of service) WW-11 132 03 7269 | | 17 INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | | | Address | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, | | | | | | | | | | RECENT |
| DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY ABSCESSSES, | | | | | | | | | | RECENT |
| DUE TO, OR AS A CONSEQUENCE OF (c) ASTROCYTOMA, GRADE II, OLD, RIGHT PARIETAL AND OCCIPITAL LOBES, CEREBRUM. | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 193. | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a I certify that (X) (this hospital) attended the deceased from 10/11/68, 19, to 11/25/68, 19, that (X) (we) last saw the deceased alive on 11/25/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE John A. Orer M.D. | | | | | | | | 22c. DATE SIGNED 11/25/68 | | |
| 22d PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D. | | | | 22e ADDRESS VAH FORT HOWARD, MARYLAND | | | | | | |
| 23a BURIAL, CREMATION, OTHER (Specify) BURIAL | | 23b DATE 11/27/68 | | 23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | | 23d LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA | | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS S. H. HINES FUNERAL HOME 14th St., N.W. WASHINGTON, D. C. | | 25a REC'D BY REGISTRAR NOV 29 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| <div style="display: flex; justify-content: space-between;"> 15495 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15507 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | | | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|---|---|--|---|---|--|--|
| 1. DECEASED-NAME (Type or print) | | | First Charles | | Middle Vivin | | Last Carey Jr. | | 2a. DATE OF DEATH Month Nov , Day 1 , Year 1968 | | | 2b. HOUR 3:30 AM | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH Aug. 6, 1923 | | | 6. AGE (In years lost birthday) 45 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore Co. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore County | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Stevenson, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTE (If not hospital give street address) Greenspring Valley Rd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Rds. Supt. | | | 12b. KIND OF BUSINESS OR INDUSTRY Retrie. Robbins | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Md. | | | 13b. COUNTY Baltio. | | | 13c. CITY OR TOWN Stevenson | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Greenspring Valley Rd. | | | |
| 14. FATHER'S NAME First Charles Middle Vivin Last Carey Sr. | | | 15. MOTHER'S MAIDEN NAME First Mae Middle Last Henery | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) W.W.II | | | 16b. SOCIAL SECURITY NO. 213-16-4369 | | | 17. INFORMANT Stevenson, Md. | | | Mrs. Margaret Carey, Greenspring Valley Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line or (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - lung - right 10x1 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April , 19 68 , to November , 19 68 , that (I) (we) last saw the deceased alive on November 1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Clarence E. Williams, M.D. | | | | | | DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11-4-68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS 11904 Reisterstown Rd Reisterstown Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Nov. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Cockeysville Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR Frank H. Newell, Reisterstown | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

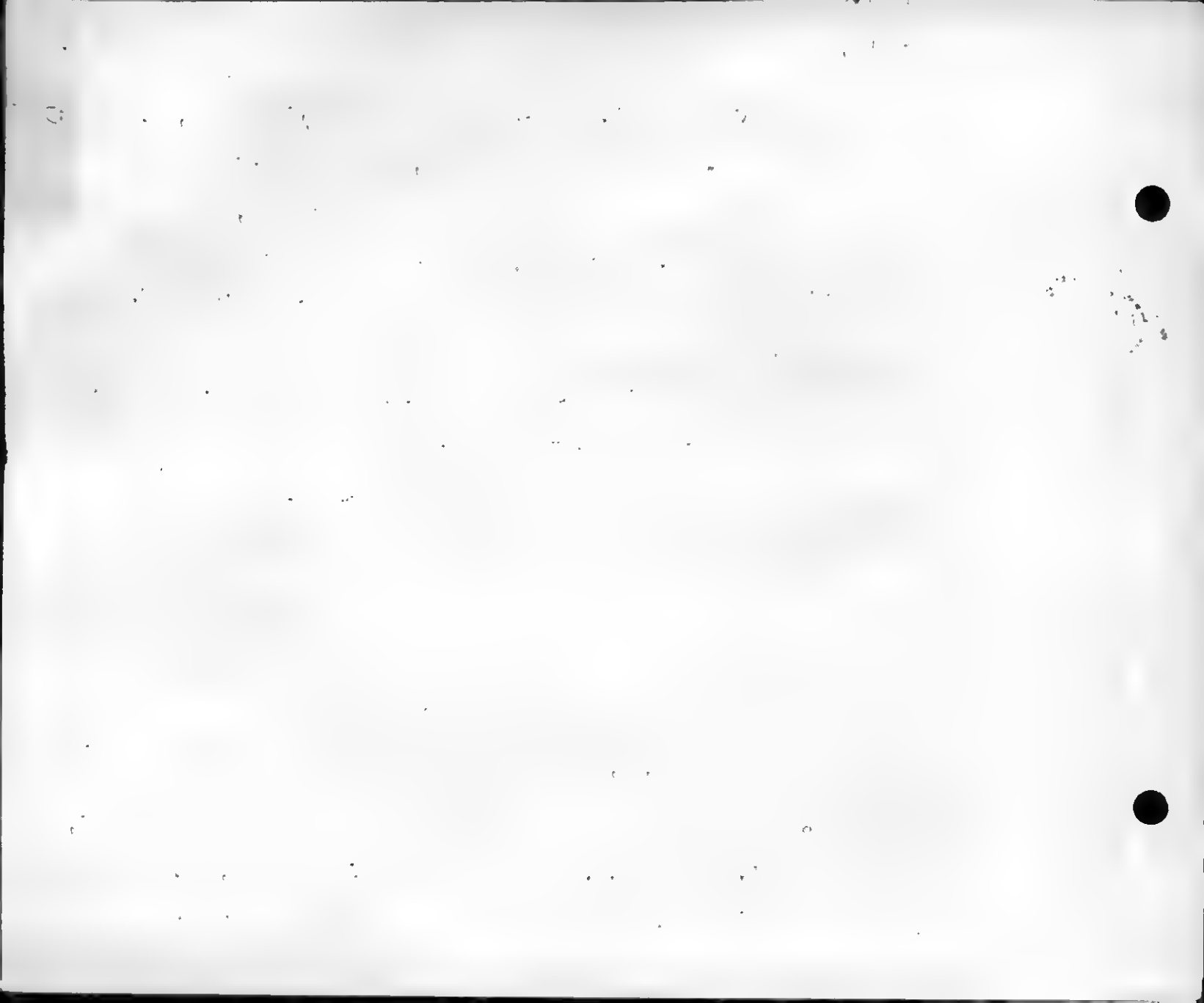
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15496

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15504
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|---------|---|-------|---|------|---|---|--|-----------------------------------|--|------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR A M | | |
| JOSEPHINE D. CARINI | | | | | | NOVEMBER 12, 1968 | | | 4:30 PM | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| FEMALE | WHITE | JUNE 11, 1885 | | | | 83 YRS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Palermo, Sicily | | USA | | | | BALTIMORE, Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TOWSON | | ST. JOSEPH HOSPITAL | | | | Seamstress | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MARYLAND | | | | BALTIMORE | | | | 1404 MERIDENE DR. #21212 | | | |
| 14 FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Santo Dell'Oglio | | | | | | Anna Anello | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | | |
| No | | | | 215-05-2396 | | Benedict J. Carini | | 906 Wellham Ave Glen Berni 21061 | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from November 3, 1968, to November 12, 1968, that (X) (we) last saw the deceased alive on November 12, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Camilo Z. Tomboc | | | | | | | | 22c. DATE SIGNED November 12, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) CAMILO Z. TOMBOC, M.D. | | | | | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON, MD. #21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 11/16/1968 | | Holy Redeemer Cemetery | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Balto. Md. | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 14 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15509

15497

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|--|------------------------|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) EDNA | | First M | Middle CARLE | Last CARLE | 2a. DATE OF DEATH Month 11 Day 12 Year 65 | | | 2b. HOUR 1 A. | |
| 3. SEX F. | | 4. RACE W. | | 5. DATE OF BIRTH 9/15/00 | | 6. AGE (In years lost birthday) 65 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (State or foreign country) W. Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | Md | |
| 10. CITY OR TOWN OF DEATH Baltimore 21228 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home | | 12a. USAL OCCUPATION (Kind of work done during most of work ng life, even if ret red) Retired R.R. | | 12b. KIND OF BUSINESS OR INDUSTRY R.R. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution adm ssion) STATE Ma | | 13b. COUNTY V | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LHM 15? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 3501 St. Paul St. | |
| 14. FATHER'S NAME First George Middle Paur | | | | 15. MOTHER'S MAIDEN NAME First Mrs. Richard Middle Holland Last 1612 Park Grove Ave. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) no | | 16b. SOCIAL SECURITY NO no | | 17. INFORMANT Mrs. Richard Holland | | Address 1612 Park Grove Ave. | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/20 Dissected - aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) hypertension C-U-D DUE TO, OR AS A CONSEQUENCE OF (c) age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. arteriosclerosis | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bands of Rigor Inguis Carcinoma Angioma | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. 19 Month 11 Day 12 Year 1965 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No 4605 City or Town EDMONDSON County NOV State 12 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 65 , to 11/12 , 19 65 , that (I) (we) last saw the deceased alive on 11/12 , 19 65 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cliff Ratliff | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN | | 22c. DATE SIGNED 11/12/65 | | | |
| 22d. PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR. M.D. | | 22e. ADDRESS 4605 EDMONDSON AVE 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 11/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Witzke | | | | ADDRESS 4101 Edmondson Ave. 21229 | | 25a. REC'D BY REGISTRAR NOV 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

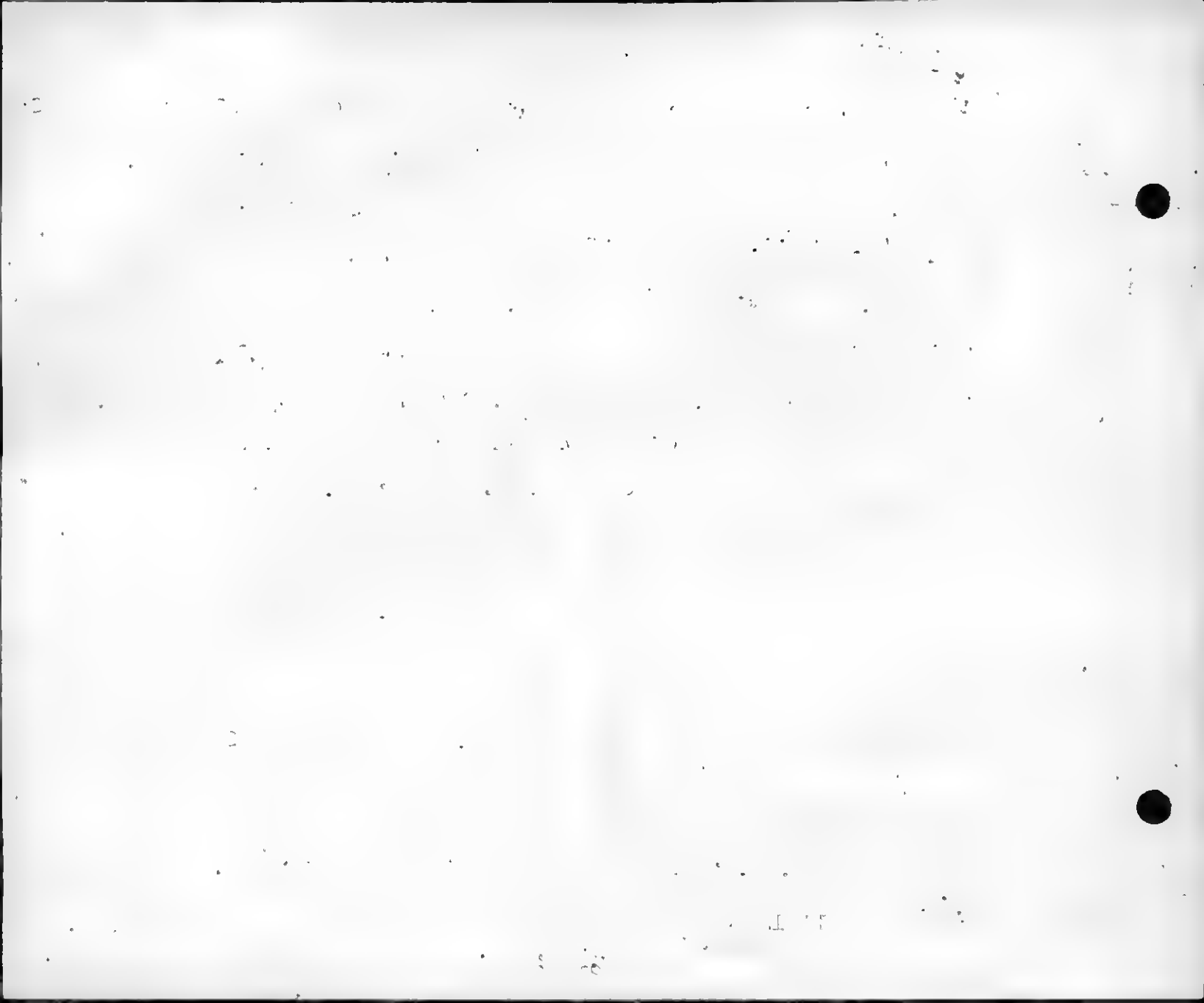
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VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

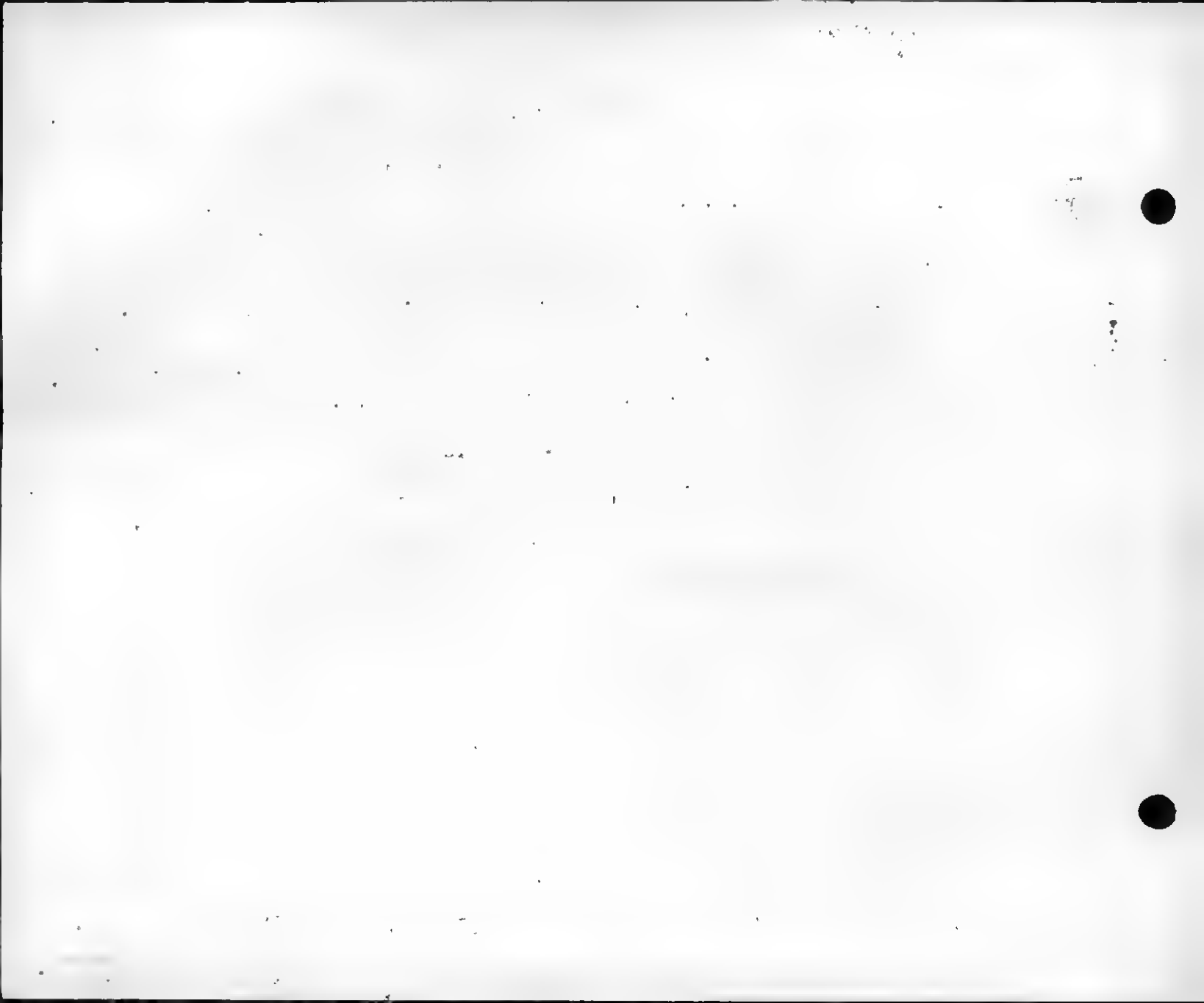
| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (Type or print) First Middle Last DANIEL LEWIS CARLIN | | | 2a. DATE OF DEATH Month Day Year NOV. 13 1968 | | 2b. HOUR 6:35 AM |
| 3 SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH 10/16/1888 | | 6. AGE (In years last birthday) 80 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE MD. (TOWSON) 21204 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES | 12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTO. 21234 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 8631 RICHMOND AVE. | |
| 14. FATHER'S NAME First Middle Last GEORGE CARLIN John Carlin | | 15. MOTHER'S MAIDEN NAME First Middle Last HELEN George Carlin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO. 324-18-7375 | 17. INFORMANT Address # Mrs. Dana Davenport AS IN # 13 Above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE AND T.B. CARIO- RESPERATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State 11/11 19 68 11/13 19 68 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/13 19 68 , to 11/13 19 68 , that (I) (we) last saw the deceased alive on 11/13 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Meshekpour, M.D. DEGREE | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) DR. H. MESHINPUR | | | | 22e. ADDRESS GBMC BALTIMORE MD. 21204 | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) CREMATION | 23b. DATE 11/14/68 | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN | | 23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES CO. MD. | |
| 24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY ADDRESS DUNDALK, MD. 21222 | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--------|---|--|
| 1. DECEASED NAME (Type or print) | | First | | Middle | | Last | | 20. DATE OF DEATH | | | 2b. HOUR |
| VIOLA | | RUTH | | CASHMAN | | 11 Month 5 Day 68 Year | | | 5:30 P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS M.N. | |
| Female | | White | | Mar. 13, 1896 | | | | 72 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Ohio | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | Caton Ridge Nursing Home | | | | Cashier | | BANK | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | WASHINGTON | | HAGERSTOWN | | YES | | 941 LANVALE ST. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Phillip B. Heefner | | | | Nellie Maugans | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | | | 220-09-9454 | | Caton Ridge N.H. CATONSVILLE MD. 329 Harlem Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | | | | | | | | | 1 1/2 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Catatonic State</u> | | | | | | | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Psychosis</u> | | | | | | | | | | | years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| <u>Multiple Decubitus ulcers</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-10-</u> , 19 <u>68</u> , to <u>11-5-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-5-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| <u>Cesar Valle Caverro</u> | | | | | | | | | | 22c. DATE SIGNED | |
| | | | | | | | | | | 11-6-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | |
| CESAR VALLE CAVERO, M.D. | | | | 8629 Liberty Road | | | | RANDALLSTOWN MD. | | | |
| 23a. BURIAL, CREMATION | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| BURIAL | | 11/7/68 | | WOLFESVILLE U.B. CH. | | WOLFESVILLE | | | | MD. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.J. Norment, Hagerstown, Md. | | | | DATE NOV 12 1968 | | | | Johnas Judge | | | |

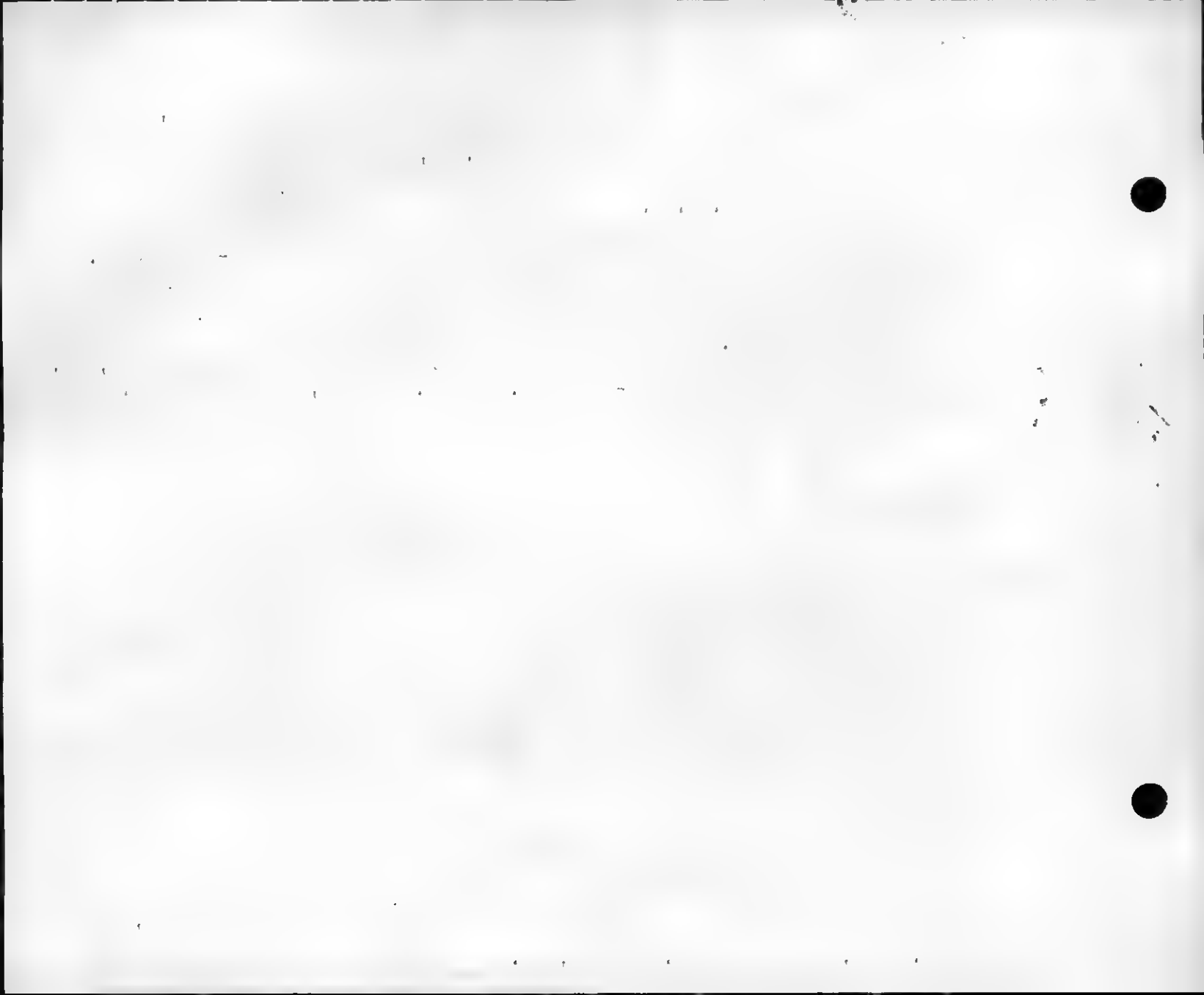


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VR A15
30M REV 68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--------|---|-----------------|--|--|--------------------------------|--|---|--|--|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | | | | |
| Fern | | | Causley | | | Month Day Year November 29, 1968 | | | 11 10 M | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | Oct. 27, 1918 | | | 50 YRS | | MONTHS DAYS | | HOURS MIN | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Kentucky | | | U. S. A. | | | | | | Baltimore | | | Md. | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Dundalk | | | 1313 Willow Road | | | | | | School Teacher - Balto. Co. | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Maryland | | | Baltimore | | | Dundalk | | | | | 1313 Willow Road | | | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| Hollie P. Harris | | | Lucinda Christian | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT (Husband) | | | Address | | | | | |
| No | | | 306-16-6841 | | | Mr. John J. Causley, 1313 Willow Rd. | | | Dundalk, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cervix & generalized metastases</u> | | | | | | | | | | | 2 years | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 171X | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION | | | City or Town | | | County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11/15, 1968, to 11/29, 1968, that (I) (we) last saw the deceased alive on 11/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | 22c DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22e. DATE SIGNED | | | | | |
| RAYMUNDO S. MAGNO | | | M.D. | | | | | | 11/30/68 | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | | | | | | | | | | |
| RAYMUNDO S. MAGNO | | | 1012 OLD NORTH MT. RD | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 12/2/68 | | | Gardens of Faith Cemetery | | | Baltimore, Maryland | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | | 25b REGISTERED | | | | | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | DEC 4 1968 | | | | | | | | |



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VR A15 (4)
300A REV. 1-68

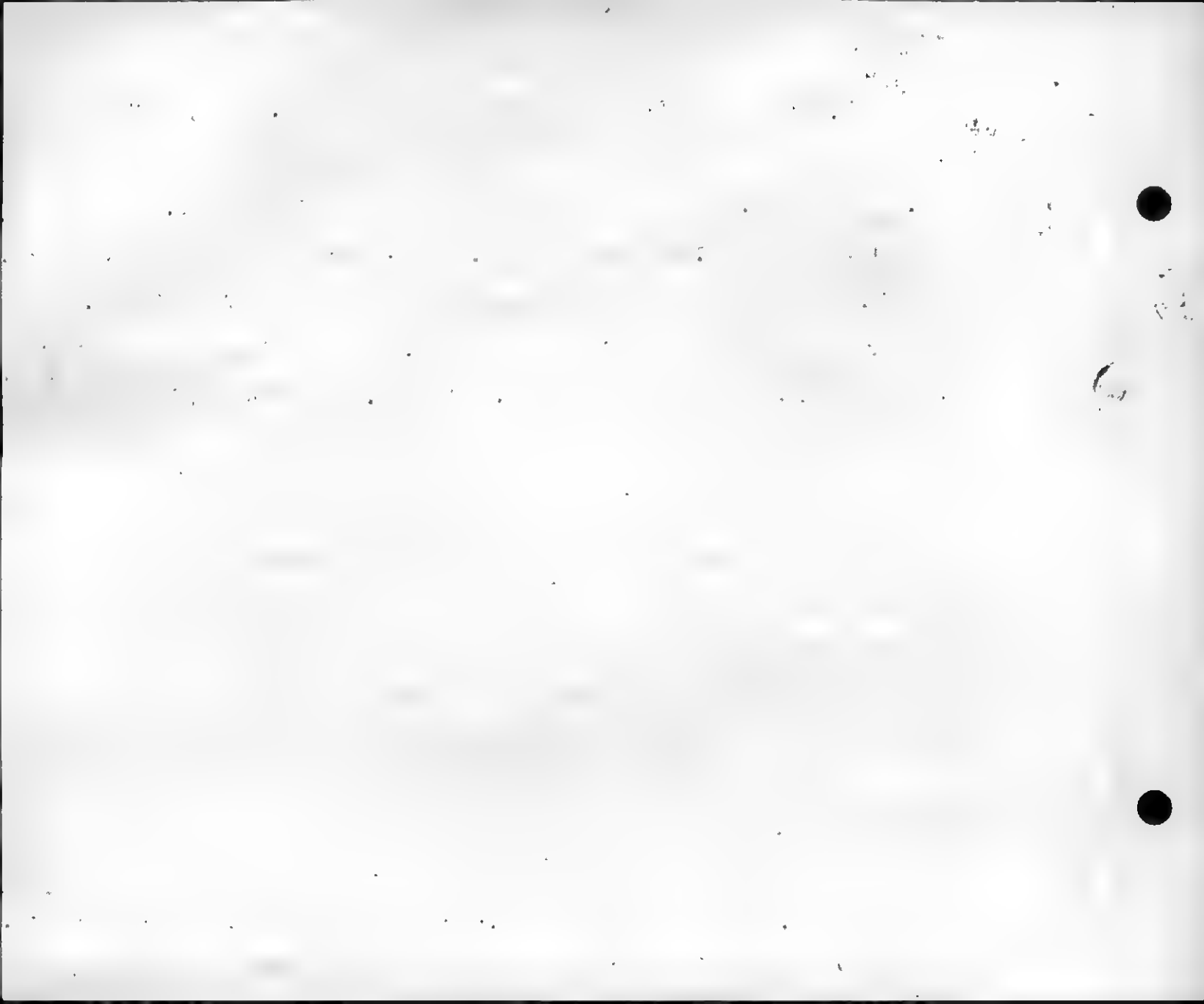
1550

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15513

CERTIFICATE OF DEATH

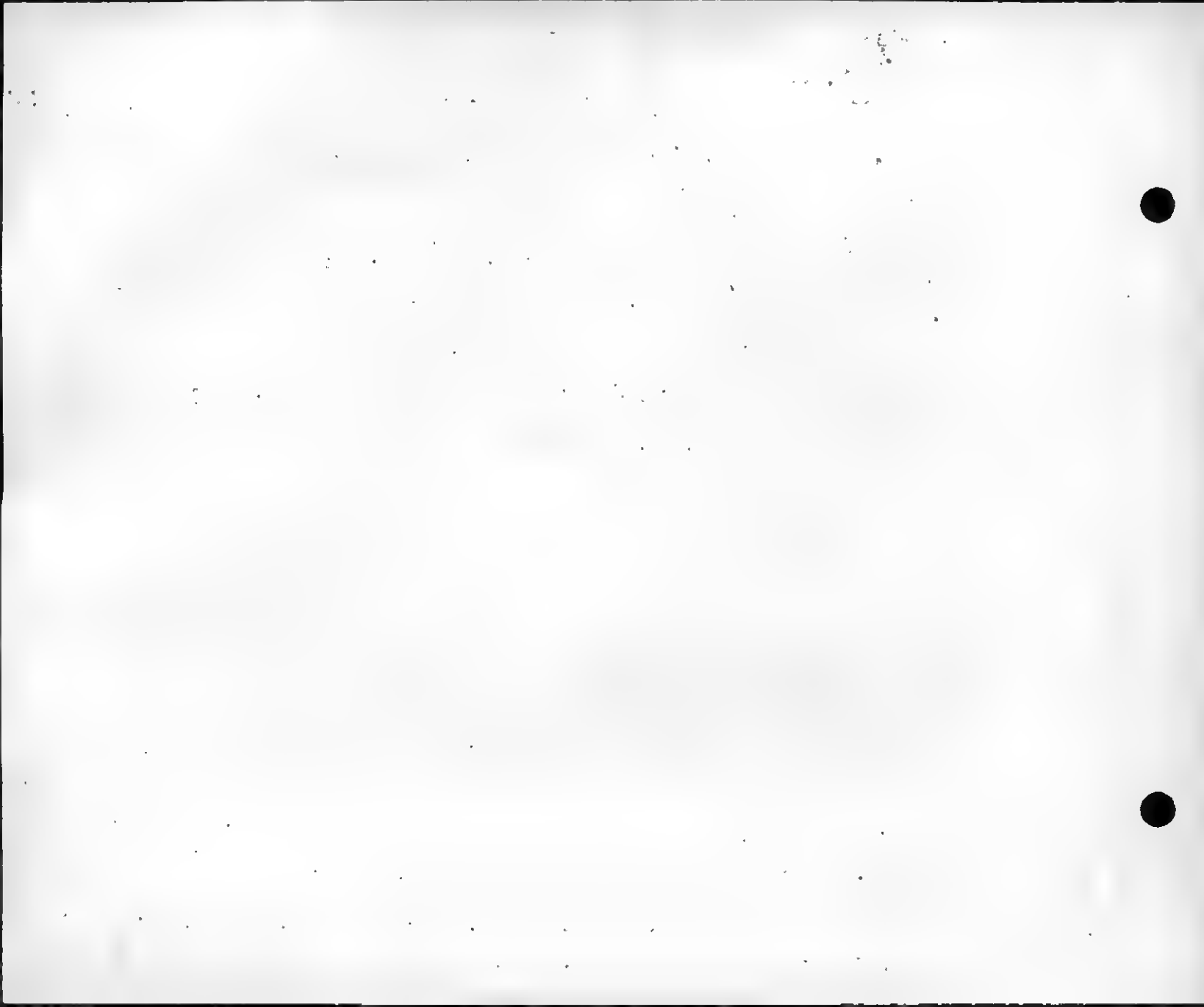
| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) Virginia | | | First Lee | | | Middle Chenoweth | | | Last | | | 2a. DATE OF DEATH Month Nov. Day 6 Year 1968 | | | 2b. HOUR M | | | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH April 27, 1912 | | | 6. AGE (In years last birthday) 56 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Co. Md | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Pikesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 4104 Milford Mill Rd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Customer Relations | | | 12b. KIND OF BUSINESS OR INDUSTRY Gen. & Elect. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Pikesville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 4104 Milford Mill Rd. | | | | | | | | |
| 14. FATHER'S NAME First Daniel | | | Middle Lambdin | | | Last Holden | | | 15. MOTHER'S MAIDEN NAME First Ada | | | Middle Blaine | | | Last Wright | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. None | | | 17. INFORMANT Address Pikesville 8, Md. Mr. William A. Chenoweth, 4104 Milford Mill Rd. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno Carcinoma Stomach DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 11/5/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | | County | | | State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 5, 1968 , to Nov 5, 1968 , that (I) (we) last saw the deceased alive on Nov 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Maurice J. Berman | | | DEGREE | | | ATTENDING PHYS. | | | MED. DIRECTOR | | | STAFF PHYS. | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type) MAURICE J. BERMAN | | | 22e. ADDRESS 2 E READ ST | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Nov. 8, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | 23d. LOCATION (City or Town) Pikesville | | | (County) Baltimore | | | (State) Md. | | | | | |
| 24. FUNERAL DIRECTOR Frank H. Newell | | | ADDRESS Pikesville 8, Md. | | | 25a. REC'D BY REGISTRAR DATE NOV 13 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>First Helen Middle D. Last Christenson</i> | | | | | 2a. DATE OF DEATH <i>Month 11 / Day 27 / Year 68</i> | | 2b. HOUR <i>11:19</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>4-24-89</i> | | 6. AGE (In years last birthday) <i>79</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) <i>Delmar</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>10 Oatonsville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Spring Grove State Hosp</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired) <i>unemployed</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if instit in residence before admission) <i>STATE</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>10</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>4301 Winkton St.</i> | |
| 14. FATHER'S NAME <i>First Michael Neff Middle Last</i> | | | | 15. MOTHER'S MAIDEN NAME <i>First Mary (Unknown) Middle Last</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO <i>336-07-699</i> | | 17. INFORMANT <i>Leonard Christenson</i> | | Address <i>3131 1/2 E. 19th St. Baltimore, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>450 X</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>460 X</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from <i>7-25</i> , 19 <i>67</i> , to <i>11-27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-27</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Vicente M. Ruelas</i> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>11-27-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>VICENTE M RUELAS</i> | | | | | 22e. ADDRESS <i>Spring Grove State Hosp.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>12-2-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Nat'l. Cemetery Balto. City, Baltimore Md.</i> | | 23d. LOCATION (City or Town) (County) (State) | | | |
| 24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave., 21229</i> | | | | | 25a. REC'D BY REGISTRAR <i>DEC 2 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15503 | | | | | | | | | | | | | |
|---|--|--------|---|-----------------|-----------------------------------|---|--------------------------------|--|--|---|-------------------|--------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15510 | | | | | | | | | | | | | |
| Item#5Film#G407 12/4/68 vmp | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH Month Day Year | | | 2b HOUR 11:30A M | | | | |
| James McVeity Christy | | | | | | November 26, 1968 | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | 7 IF UNDER 24 HRS | | |
| Male | | White | | April 18, 1900 | | | 68 YRS | | MONTHS DAYS | | HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Ottawa, Canada | | | U.S.A. | | | | | | Baltimore Co. | | | Md. | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Randallstown | | | Baltimore Co. Gen. Hosp | | | Watchmen | | | Baltimore City | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 13e STREET AND NUMBER | |
| Maryland | | | Baltimore | | | Owings Mills | | | | | | 16 Kingsley Rd. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| George Christy | | | Harriet McVeity | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | Address | | | | |
| No | | | 220-28-3705 | | | Mrs. Dorothy Christy Owings Mills, Md. | | | 16 Kingsley Rd., | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | 30 min | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | | | | |
| 4107 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | 10 yrs. | | | |
| (b) Arteriosclerotic Cardio Vascular Disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR COMPLICATED <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| None | | | | | | | | | | | | | |
| 21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | | 21c LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-17-41, 19, to 11-26-68, 19, that (I) (we) last saw the deceased alive on Nov. 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 11-27-68 | |
| 22d. PHYSICIAN'S NAME (Type) D. D. Caples, M. D. | | | | | | | | 22e ADDRESS 6 Hanover Rd., Reisterstown, Md. 21136 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | Nov. 29, 1968 | | Good Shepherd Cem. | | | Ellicott City, Howard, Md. | | | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| H. J. Ellhardt | | | Owings Mills, Md. | | | DATE DEC 2 1968 | | | M. L. Oude | | | | |

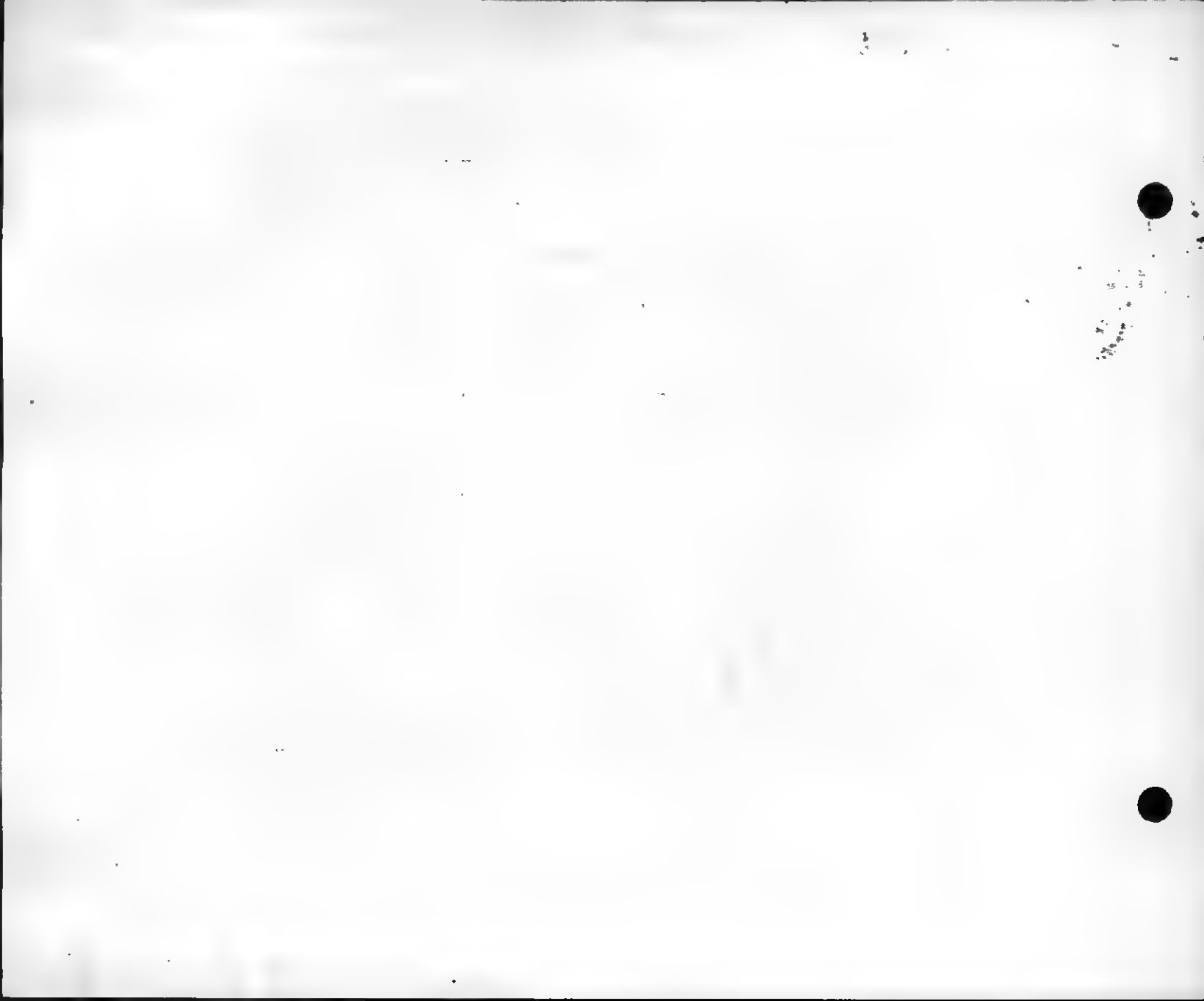


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|------------------------------|---|---|--|---|--|----------------------------|--|-------|------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Sarah | | | CITRANO | | | November 25 1968 | | | 5:15 PM | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | White | | 2-2-1888 | | | 80 YRS | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Italy | | Italy | | | | Baltimore Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | | St. Joseph Hospital | | | Housewife | | | Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Md. | | | Balto. | | | | YES | | 8227 Pleasant Plains Rd. | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| Joseph Pitarra | | | Mariana DeAlonso | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | | | | |
| No | | | 217-54-9168 | | Jennie Citrano, 8227 Pleasant Plains Rd. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) | | | | | | | | | | 21204 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 422 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat. ly med cal examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-19, 1968, to 11-25, 1968, that (I) (we) last saw the deceased alive on 11-25-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | |
| Camilo Z. Tomboc | | | 11-25-68 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| Camilo Z. Tomboc, M.D. | | | 7620 York Road, Towson, Maryland 21204 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | 11-29-68 | | Most Holy Redeemer | | Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Johnson Funeral Home | | | 8521 Loch Raven Blvd. | | | DATE NOV 29 1968 | | Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV 1/68

| <div style="text-align: center;"> <div>15505</div> <div> <div>DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15517</div> </div> </div> | | | | | | | | | | | |
|---|--|--|--|---|--|--|---------------------------------|---|-------------------------------------|--|----------------------------|
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR A | | |
| CHARLES | | | TILGHMAN | | | CLARK | | | November 15, 1968 5:25 ^M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| Male | | White | | 7-8-01 | | | 67 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Maryland | | USA | | | | | Baltimore | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | St. Joseph Hospital | | | Broker | | | Real Estate | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21218 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Gustavus Clark | | | Mary S. Brown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT Address | | | | | |
| No | | | 215-10-7803 | | | Mrs. Bertha L. Clark | | | (Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Thrombosis of left anterior descending coronary artery | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Severe coronary atherosclerosis | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from November 15 19 68, to Nov. 15, 19 68, that (X) (we) last saw the deceased alive on November 15 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Lawrence J. Misanik</i> | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) Lawrence J. Misanik, M.D. | | | | | | | | 22e. ADDRESS 3620 York Road, Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 11/18/68 | | Dulaney Valley Mem Grds | | Timonium, Balto Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md. | | | | | | 25. DATE BY WHICH THIS CERTIFICATE MUST BE FILED NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/62

Items 4, 13, 14, 15, 17
Film 407 12/9 60 KK
Item 3 15506
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15518

| | | | |
|--|--|---|-------------------------------------|
| 1 PLACE OF DEATH a COUNTY <u>Baltimore Maryland</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. LENGTH OF STAY IN TB <u>30 yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8100 Dundalk Avenue</u> | | d STREET ADDRESS <u>8100 Dundalk Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Levin</u> Last <u>Collison</u> | | 4. DATE OF DEATH <u>Nov. 21, 1968</u> | |
| 5 SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B DATE OF BIRTH <u>9/20/01</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Soleman</u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Cyford Maryland</u> | | 12 C.T. ZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Andrew Collison</u> | | 14 MOTHER'S MARDEN NAME <u>Hester A. M. Boon</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1920-1932</u> | | 16. SOCIAL SECURITY NO <u>216-10-6112</u> | |
| 17. INFORMANT <u>Floyd L. Collison 8100 Dundalk Ave. 21222</u> | | Address <u>Balto. Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4100</u> DUE TO <u>acute Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>HCVI</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART (a) <u>4</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/10/68</u> 19 <u>68</u> to <u>present</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/18/68</u> 19 <u>68</u> , and that death occurred at <u>11:15 PM</u> , from causes and on the date stated above. | | | |
| 22a SIGNATURE <u>Theo C Patterson</u> | | 22b DATE SIGNED <u>11/21/68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>THEO C PATTERSON</u> | | 22d ADDRESS <u>3427 Dundalk Ave 21222</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 23b DATE THEREOF <u>11-26-68</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Medical School</u> | |
| 23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u> | | 25a REC'D BY REGISTRAR <u>DEC 2 1968</u> | |
| 24. FUNERAL DIRECTOR <u>Ullrich Funeral Home Dundalk, Md.</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



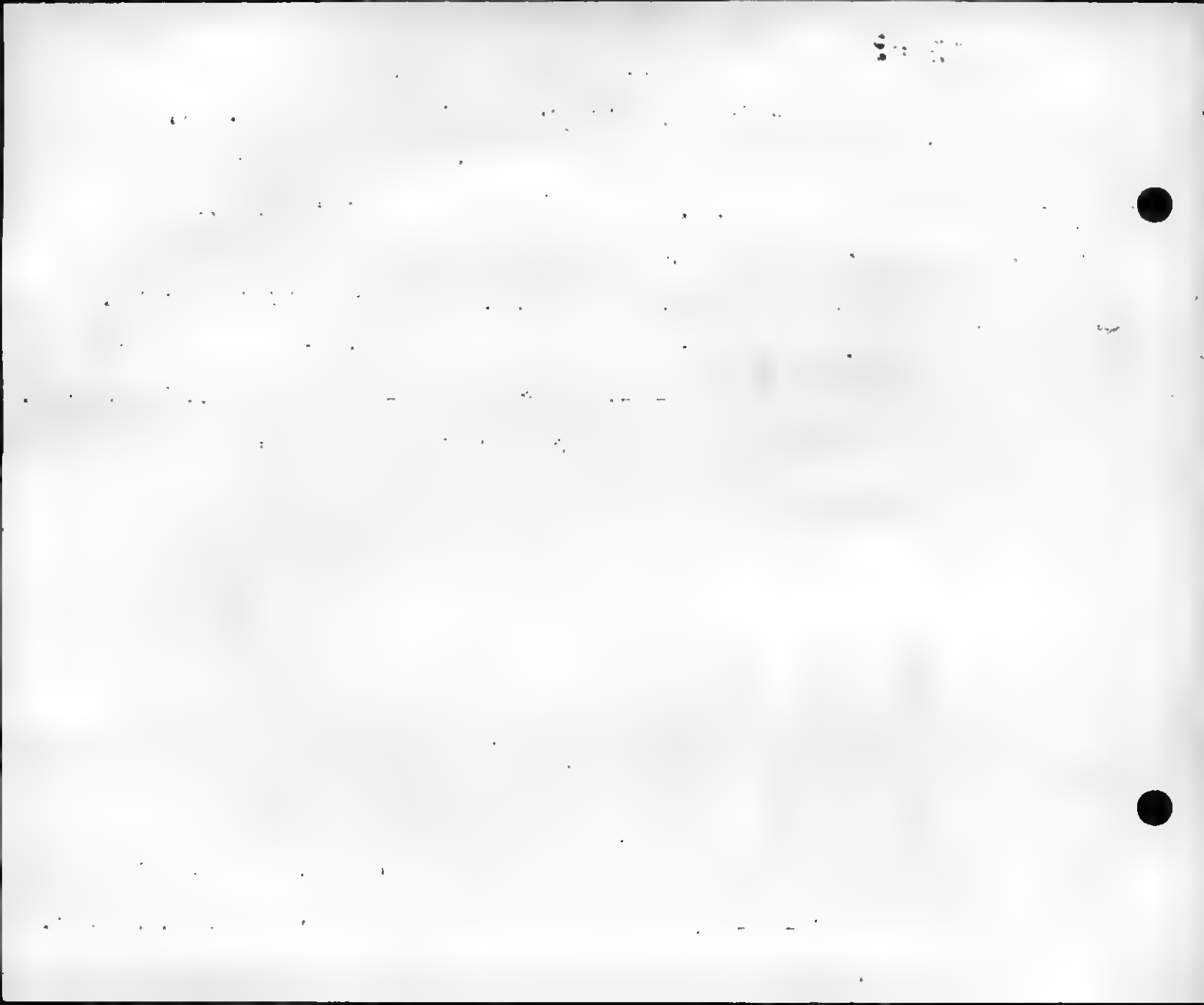
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15507

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15519
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) ALEXANDER First PAUL A. Middle CONNOR Last | | | 2a. DATE OF DEATH Month Nov. Day 11 , Year 1968 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH Aug. 2, 1882 | | 6. AGE (in years last birthday) 86 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) England | 7b. CITIZEN OF WHAT COUNTRY? U. S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Co., Md. | | |
| 10. CITY OR TOWN OF DEATH Catonsville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Balto. Highland | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 3011 Maryland Ave. | |
| 14. FATHER'S NAME First Capt. Tim Middle Connor Last | | 15. MOTHER'S MAIDEN NAME First Marie Middle Margeson Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 216-10-0179 | | 17. INFORMANT Address Marie Lingg - 3908 Eighth St., Baltimore, Md. | |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA PROSTATE - METASTATIC 185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177X A.C.V.H.D | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-5 , 19 68 , to 11-11 , 19 68 , that (I) (we) last saw the deceased alive on 11-5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John F. Schaefer M.D. | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 11/11/68 | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER | | 22e. ADDRESS 401 RANDOM RD. - BALTO. MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11-14-1968 | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | 23d. LOCATION (City or Town) (County) (State) Ritchie Hwy., A.A. Co., Md. | | |
| 24. FUNERAL DIRECTOR George J. Gonce | | ADDRESS 1001 Ritchie Hwy., Baltimore | 25a. REC'D BY REGISTRAR NOV 19 1968 | 25b. REGISTRAR'S SIGNATURE Charles J. J... | |

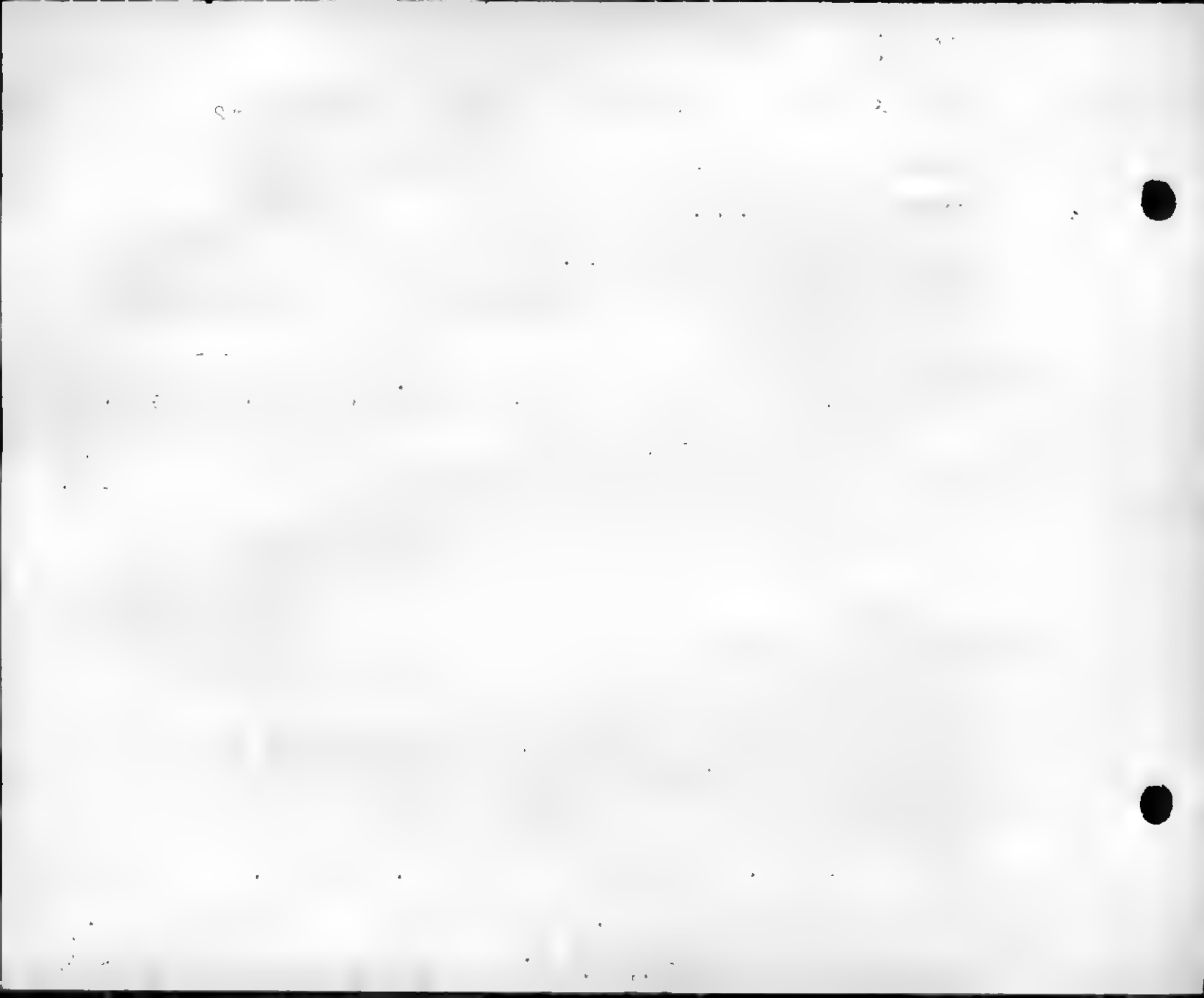


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45M

| 15508 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15520 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EDGAR CIARENCE COOPER | | | | | | | | | | NOVEMBER 12 1968 | | | | | | | | | | 11:15p M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX MALE | | | | | | | | | | 4. RACE WHITE | | | | | | | | | | 5. DATE OF BIRTH 6/30/98 | | | | | | | | | | 6. AGE (In years last birthday) 70 YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Kentucky Maryland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) SUPERVISOR | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND | | | | | | | | | | 13b. CITY OR TOWN BALTIMORE | | | | | | | | | | 13c. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 4417 MARBLE HALL ROAD | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last CIARENCE - - COOPER | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last GERTRUDE - - McBRIDE | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES | | | | | | | | | | 16b. SOCIAL SECURITY NO. 212 03 42 77 | | | | | | | | | | 17. INFORMANT Mrs. C. Ethel Cooper Address Same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE | | | | | | | | | | 6 YEARS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. DEATH WAS CAUSED BY (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART III. DEATH WAS CAUSED BY (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from OCT 29, 1968, to NOV 2, 1968, that (we) last saw the deceased alive on NOV 2, 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Erhard J. Bunyor DEGREE | | | | | | | | | | 22c. DATE SIGNED 11/3/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ERHARD J. BUNYOR | | | | | | | | | | 22e. ADDRESS VAH, FT. HOWARD, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | | 23b. DATE 11/6/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR RUCK FUNERAL HOME | | | | | | | | | | 25a. REC'D BY REGISTRAR NOV 4 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



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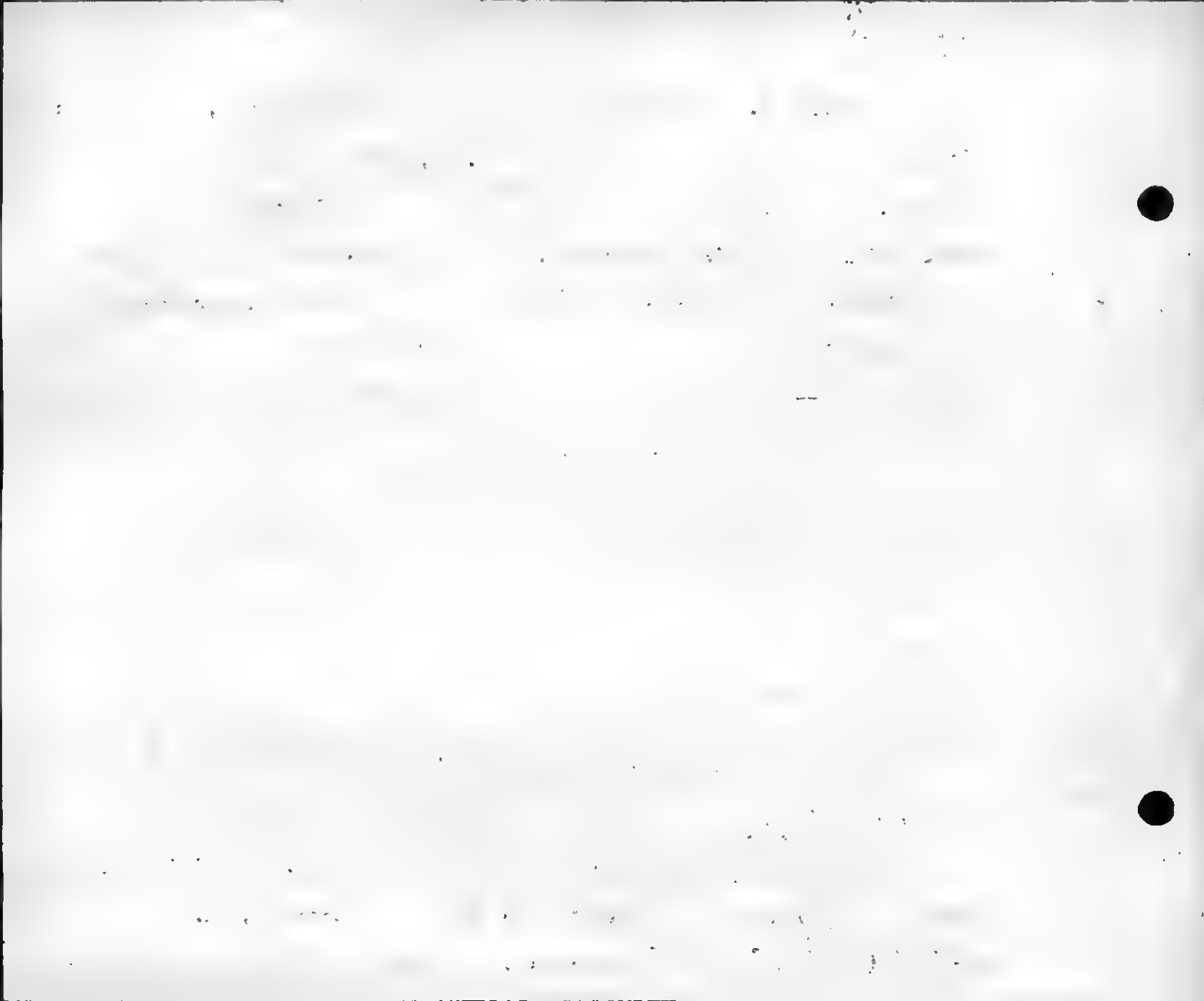
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| CARL | | | SWINTON COPPEDGE | | | NOV 9 1968 | | 9:30 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | |
| MALE | | WHITE | | 10-28-93 | | 75 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| GEORGIA | | U. S. A | | | | Baltimore County, Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Mount Wilson | | | Mt. Wilson St. Hosp. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIM TS? | | 13e. STREET AND NUMBER | |
| MD. | | | - V | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 102 N. PACA ST. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| JULIAN | | | COPPEDGE | | | LILLA MUNNALLY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| YES | | | 253-20-5993 | | Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) (c) | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| Pulmonary tuberculosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-15-1968, to 11-9-1968, that (I) (we) last saw the deceased alive on 11-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | |
| W. Newcomer | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| William Newcomer, M.D. | | | | | | Mount Wilson, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVA. (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| Burial | | Nov. 14, 1968 | | New Catholic Cemetery | | Baltimore | | Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Frank D. Newell | | | | | | DATE NOV 19 1968 | | Charles J. J... | | |



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|----------------------------|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH Month | | 2b. HOUR | |
| BINNIE G. CRITCHFIELD | | | | | | | | November 10, 1968 | | 7:40AM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | Cau | | Nov. 28, 1890 | | 77 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Penna. | | USA | | | | Baltimore | | | | Md | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Essex 21221 | | 1029 Eastern Ave. | | housewife | | Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Baltimore | | Essex 21221 | | | | 1029 Eastern Avenue | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Joseph Auman | | | | Minerva Walker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 172 18 9979B | | Paul Critchfield | | Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Ovary</u> 1730 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/67, 19, to 11/68, 19, that (I) (we) last saw the deceased alive on 11/9/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. S. Lyden M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>R. S. LYDEN, M.D.</u> 22e. ADDRESS <u>6402 GULDEN AVENUE BALTIMORE</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Removal | | 11/12/68 | | Hauger Funeral Home | | Somerset, Pa. | | | | | |
| 24. FUNERAL DIRECTOR <u>Brazdzinski Funeral Home</u> ADDRESS <u>1407 Eastern Ave.</u> | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | DATE NOV 13 1968 | | <u>Charles Judge</u> | | | | | |



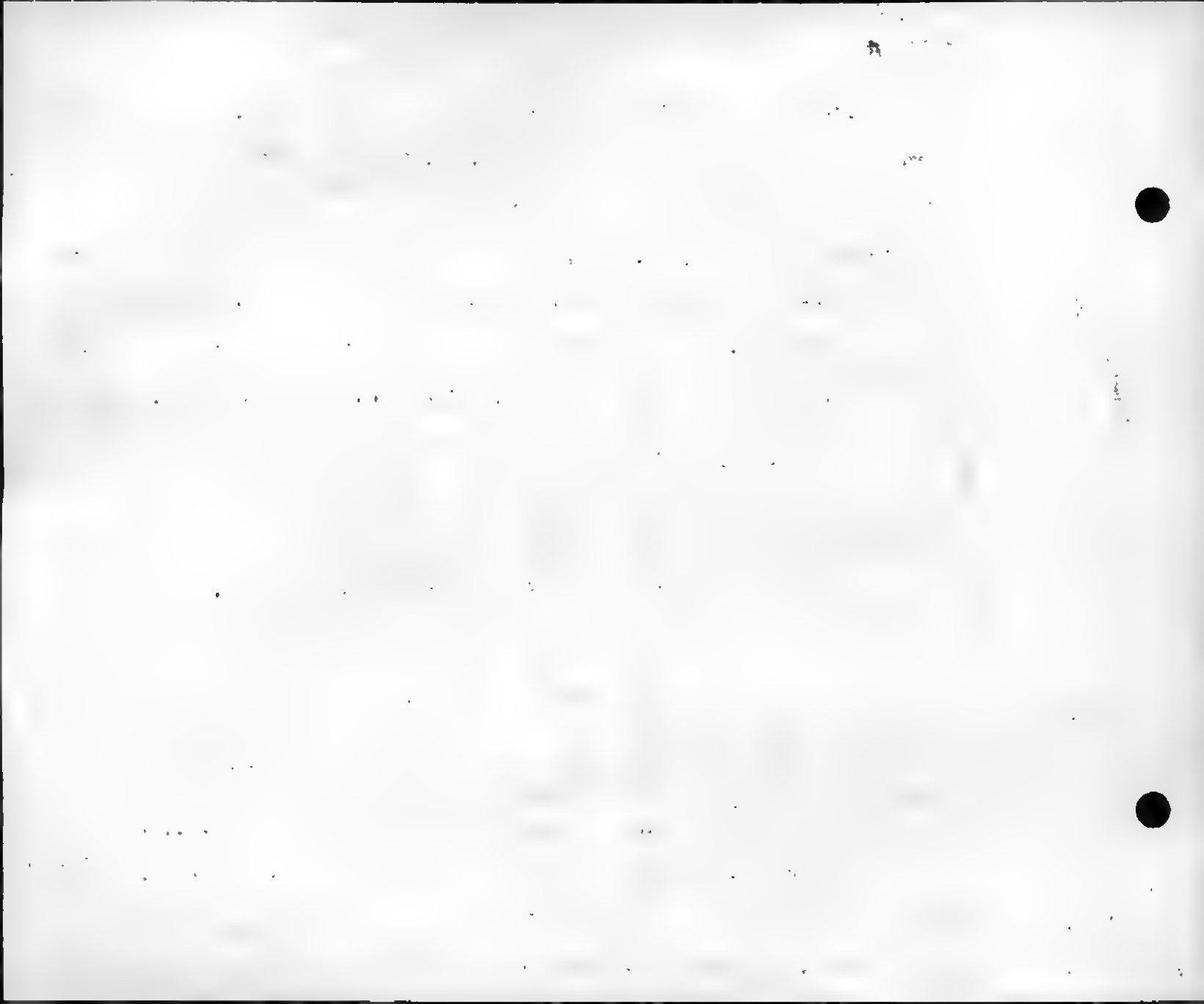
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|--|--|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | 2b HOUR | |
| ALVA Virginia CROSS | | | | | | Month Day Year Nov. 23 1968 | | 8 P M | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Jan. 15, 1877 | | 91 YRS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 3503 St. James Road | | Housewife | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Baltimore | | Baltimore | | | | 3503 St. James Road | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Isaac W. Daugherty | | | Rita - Dizoe | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | None | | Mrs. Katherine Evans, Same as 13. abcde | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE _____ | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED Nov. 25, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Leonard Golombek | | | | 22e. ADDRESS Liberty Rd., Baltimore, Md. 21207 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/29/68 | | Sunnyridge Cemetery | | Crisfield, Somerset, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Bradshaw & Sons, Crisfield, Md. 21817 | | | | DEC 2 1968 | | Charles Judge | | | |

MEDICAL CERTIFICATION



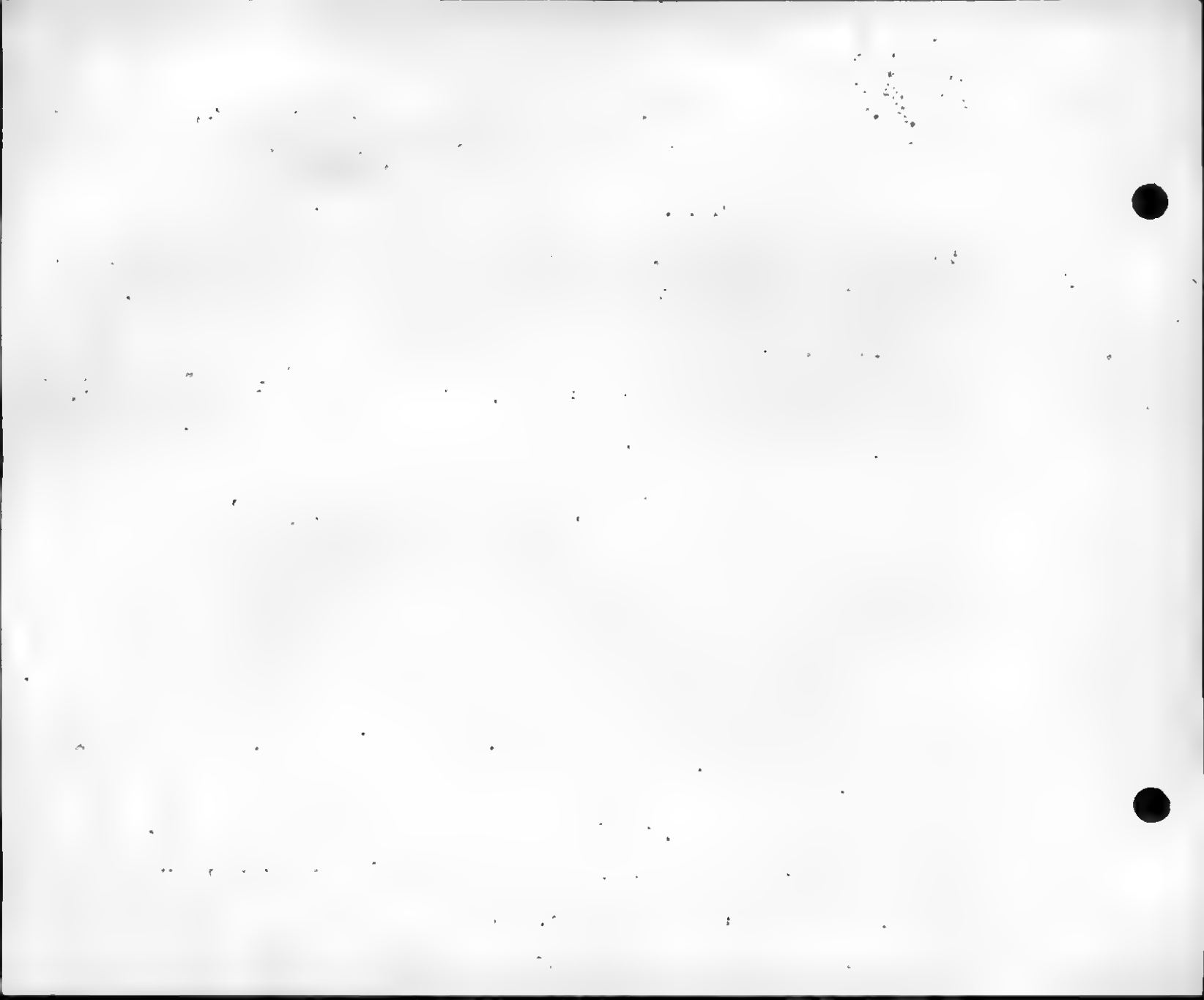
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 M
304A REV. 1/68

| 15512 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15524 | |
|--|--|--|---|--|--|---|--|--|--|---|--|--|--|------------------|------|----------|--|--|--|-------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | | Middle | | | Last | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| CHARLES | | | Randolph | | | XXX | | | DAUGHTON | | | November 22, 1968 | | | | 4:15 PM | | | | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| Male | | | White | | | December 18, 1884 | | | 83 | | | MONTHS DAYS | | HOURS MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Baltimore | | | Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Towson | | | St. Joseph Hospital | | | Electrician | | | Electrical | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIM. '37 | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | Baltimore | | | Towson | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 122 Willow Ave. | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | |
| First | | | Middle | | | Last | | | First | | | Middle | | | Last | | | | | | |
| John R. Daughton | | | Konnie Krell | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INEDMANT | | | Address | | | | | | | | | | | | |
| No | | | 217-22-3687 | | | Mrs. Margaret H. Daughton | | | 122 Willow Ave. Towson, Md. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | 21204 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Embolism | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| 4109 (b) Arteriosclerotic Cardio-Vascular Disease, | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure, | | | | | | | | | | | | | | | | | | | | | |
| (c) Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 42-1 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Nov. 11, 1968, to Nov. 22, 1968, that (X) (we) last saw the deceased alive on Nov. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | |
| Jaime M. Punzalan | | | Nov. 22, 1968 | | | Jaime M. Punzalan | | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | |
| Burial | | | 11/26/1968 | | | Jarrettsville | | | Jarrettsville, Harford Md | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Charles E. Kurtz Jarrettsville, Md. | | | NOV 26 1968 | | | J. Charles Young | | | | | | | | | | | | | | | |

21084



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15512 MARYLAND STATE DEPARTMENT OF HEALTH 15520 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--------------------|---|---|--|--|---|--|---|--|--|--|
| 1 DECEASED-NAME (Type or Print) First Middle Last JAMES JACKSON DAY SR. | | | | | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year November 6 1968 | | 2b HOUR OF ESTIMATED DEATH 5:30 P.M. | | | |
| 3 SEX M | 4 RACE W | 5. DATE OF BIRTH 12-13-1944 | 6 AGE (In years last birthday) 23 YRS | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD November 6 1968 | | 2d HOUR 5:30 P.M. | | | |
| 7a BIRTHPLACE (State or foreign country) W. VA. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH JARRETTSVILLE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH'S HOSP | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ATTENDANT | | 12b KIND OF BUSINESS OR INDUSTRY GASOLINE STATION | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | | | 13b. COUNTY 1 | | 13c. CITY OR TOWN BALTO. | | 13d INSIDE CITY, if 15? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 2315 E. FAYETTE ST. | |
| 14. FATHER'S NAME First Middle Last ROBERT E. DAY | | | | 15. MOTHER'S MAIDEN NAME First Middle Last MAUDE HENNINGER | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO. None | | 17 INFORMANT Mrs. Amelia A. Day | | ADDRESS 2315 E. Fayette St. | | | | | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fluid loss from Burns over 70% of Body Surface 7 Days and (b), if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 916.6 None | | | | | | | | | | | |
| 19a DATE OF OPERATION 10-3-68 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED None - For Airway | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year 3:30 P.M. 10/31/68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fumes in Bay of Service Station Ignited | | | | | | | |
| 21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Filling station | | 21f LOCATION (Street or R.F.D. No. 1 , City or Town Jarrettsville , County Jefferson , State MD.) Body Burned | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED 11/7/68 | | | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) BALTO. MD. | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-9-68 | | 23c. NAME OF CEMETERY OR CREMATORY DAK LAWN CEM. | | | | 23d. LOCATION (City or Town) (County) (State) BALTO. MD. | | | |
| 24 FUNERAL DIRECTOR Garley Miller - 2334 Jefferson St. | | | | 25a REC'D BY REGISTRAR DATE NOV 12 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | | | |

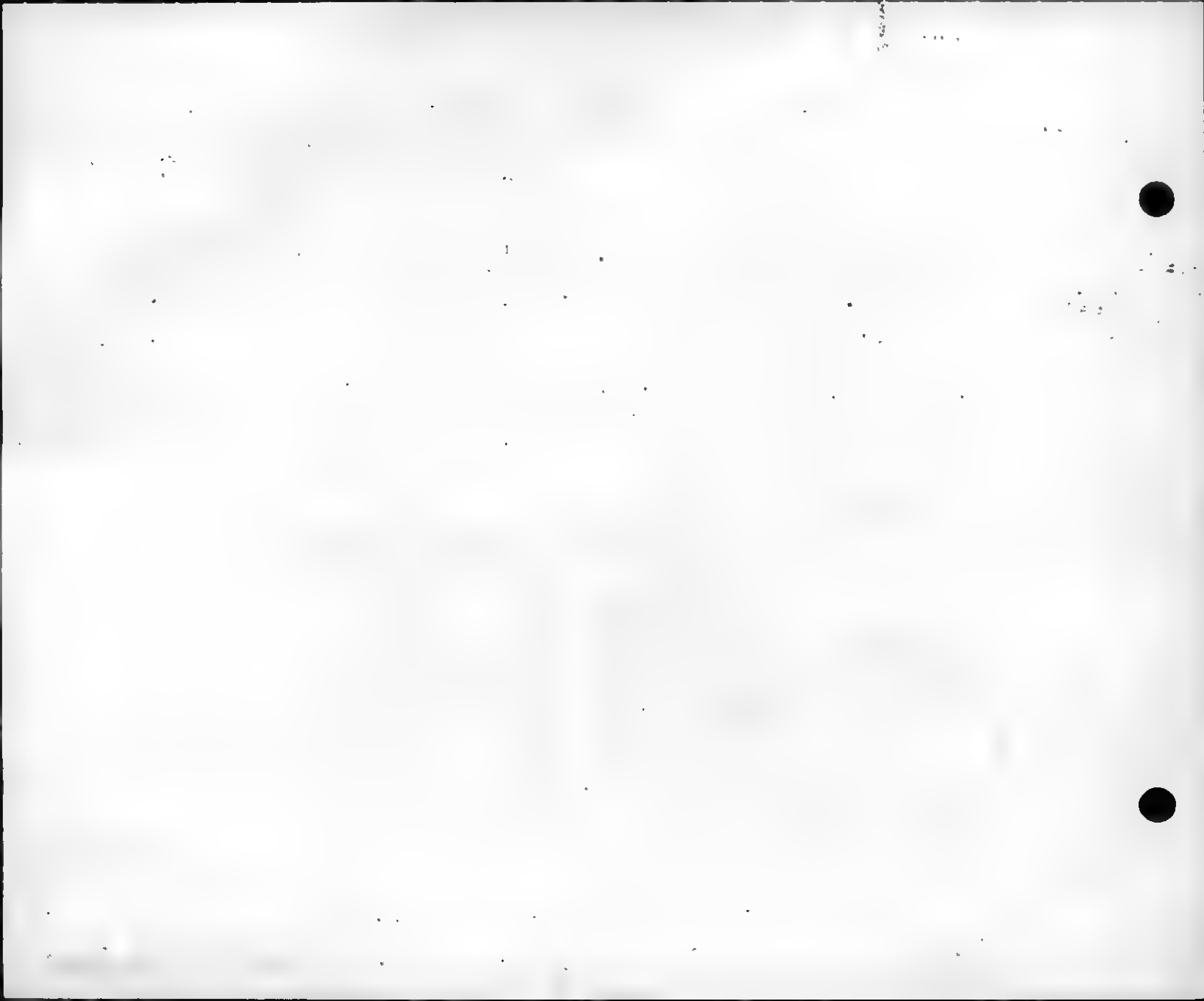


FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--------|-----------------------------|--|--|------|---|-----|-------------------------|---|--|---------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| Julius Anthony Denver | | | | | | Month Day Year | | | M | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | | 2d HOUR |
| Male | White | 8/3/13 | 55 | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | M |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | 10 | | |
| Maryland | | U.S.A | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | | Md. | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore, Towson | | | St. Joseph's | | | Race Track | | | Race Track | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY, HTS? | | |
| Md. | | | Baltimore | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET AND NUMBER | | | 13f | | | 13g | | | 13h | | |
| 2614 Moore Ave. | | | | | | | | | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b SOCIAL SECURITY NO | | |
| PETER | | | DENVER | | | ALICE | | | PORTOFEY | | |
| 16c | | | 16d | | | 16e | | | 16f | | |
| 2134 | | | 2134 | | | 2134 | | | 2134 | | |
| 17 INFORMANT | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| MRS. THEMA L. DENVER | | | Coronary Occlusion | | | 11/27/68 | | | 1 | | |
| 20 AUTOPSY? | | | 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | CAUSE OF DEATH | | | 19 | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | |
| AT WORK <input type="checkbox"/> | | | | | | | | | County | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from | | | 22b DATE SIGNED | | | 22c | | | 22d | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 11/24/68 | | | | | | | | |
| 22e | | | 22f | | | 22g | | | 22h | | |
| CHIEF MEDICAL EXAMINER | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | |
| Robert E. Altendore | | | FURNERAL HOME, INC. | | | BURIAL | | | 11/27/68 | | |
| 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) | | | 23e | | | 23f | | |
| MORELAND MEM. CEMETERY | | | BALTIMORE, MD. | | | | | | | | |
| 23g | | | 23h | | | 23i | | | 23j | | |
| 23k | | | 23l | | | 23m | | | 23n | | |
| 23o | | | 23p | | | 23q | | | 23r | | |
| 23s | | | 23t | | | 23u | | | 23v | | |
| 23w | | | 23x | | | 23y | | | 23z | | |
| 23aa | | | 23ab | | | 23ac | | | 23ad | | |
| 23ae | | | 23af | | | 23ag | | | 23ah | | |
| 23ai | | | 23aj | | | 23ak | | | 23al | | |
| 23am | | | 23an | | | 23ao | | | 23ap | | |
| 23aq | | | 23ar | | | 23as | | | 23at | | |
| 23au | | | 23av | | | 23aw | | | 23ax | | |
| 23ay | | | 23az | | | 23ba | | | 23bb | | |
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| 23bo | | | 23bp | | | 23bq | | | 23br | | |
| 23bs | | | 23bt | | | 23bu | | | 23bv | | |
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| 23ca | | | 23cb | | | 23cc | | | 23cd | | |
| 23ce | | | 23cf | | | 23cg | | | 23ch | | |
| 23ci | | | 23cj | | | 23ck | | | 23cl | | |
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| 23cq | | | 23cr | | | 23cs | | | 23ct | | |
| 23cu | | | 23cv | | | 23cw | | | 23cx | | |
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| 23dc | | | 23dd | | | 23de | | | 23df | | |
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| 23do | | | 23dp | | | 23dq | | | 23dr | | |
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| 23km | | | 23kn | | | 23ko | | | 23kp | | |
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| 23lc | | | 23ld | | | 23le | | | 23lf | | |
| 23lg | | | 23lh | | | 23li | | | 23lj | | |
| 23lk | | | 23ll | | | 23lm | | | 23ln | | |
| 23lo | | | 23lp | | | 23lq | | | 23lr | | |
| 23ls | | | 23lt | | | 23lu | | | 23lv | | |
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| 23tw | | | 23tx | | | 23ty | | | 23tz | | |
| 23ua | | | 23ub | | | 23uc | | | 23ud | | |
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| 23vw | | | 23vx | | | 23vy | | | 23vz | | |
| 23wa | | | 23wb | | | 23wc | | | 23wd | | |
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| 23xg | | | 23xh | | | 23xi | | | 23xj | | |
| 23xk | | | 23xl | | | 23xm | | | 23xn | | |
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| 23xs | | | 23xt | | | 23xu | | | 23xv | | |
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| 23yi | | | 23yj | | | 23yk | | | 23yl | | |
| 23ym | | | 23yn | | | 23yo | | | 23yp | | |
| 23yq | | | 23yr | | | 23ys | | | 23yt | | |
| 23yu | | | 23yv | | | 23yw | | | 23yx | | |
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| 23zk | | | 23zl | | | 23zm | | | 23zn | | |
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| 23zw | | | 23zx | | | 23zy | | | 23zz | | |



TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) First Middle Last CHARLES LOUIS DEPPER | | | | | | 2a. DATE OF DEATH Month 11 Day 15 Year 68 | | | 2b. HOUR 9:30 AM | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH October 8, 1900 | | 6. AGE (In years last birthday) 68 YRS. | | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN _____ | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO., MED. CENTER | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Millworker | | | 12b. KIND OF BUSINESS OR INDUSTRY Mill | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY - MITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1416 Mill Race Rd. | | |
| 14. FATHER'S NAME First Middle Last George Depfer | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Laura L. Morrison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No. | | 16b. SOCIAL SECURITY NO. 215-07-6335 | | 17. INFORMANT Address Mrs. Margaret V. Depfer-1416 Mill Race Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEPTICEMIA W/UREMIA 11-17 DUE TO, OR AS A CONSEQUENCE OF (b) MARKEDLY ADVANCED METASTATIC CA OF THE NECK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) W/NECROSIS. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 10-17 DELAYED SKIN FLAP FOR HUGE | | | | | | | | | | | |
| 19a. DATE OF OPERATION 10/22/68-10/28/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CERVICOFACIAL DEFECT | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State 10/28 68 11/15 68 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/7/57 to 11/15/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE MANUEL GATCHALIAN, MD | | | | | | 22c. DATE SIGNED 11/15/68 | | | | | |
| 22d. PHYSICIAN'S NAME MANUEL GATCHALIAN, MD | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | | 23d. LOCATION (City or Town) (County) (State) Balto., Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Austin F. Donovan-3818 Roland Ave. | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR
30M NOV 7 1968

15518

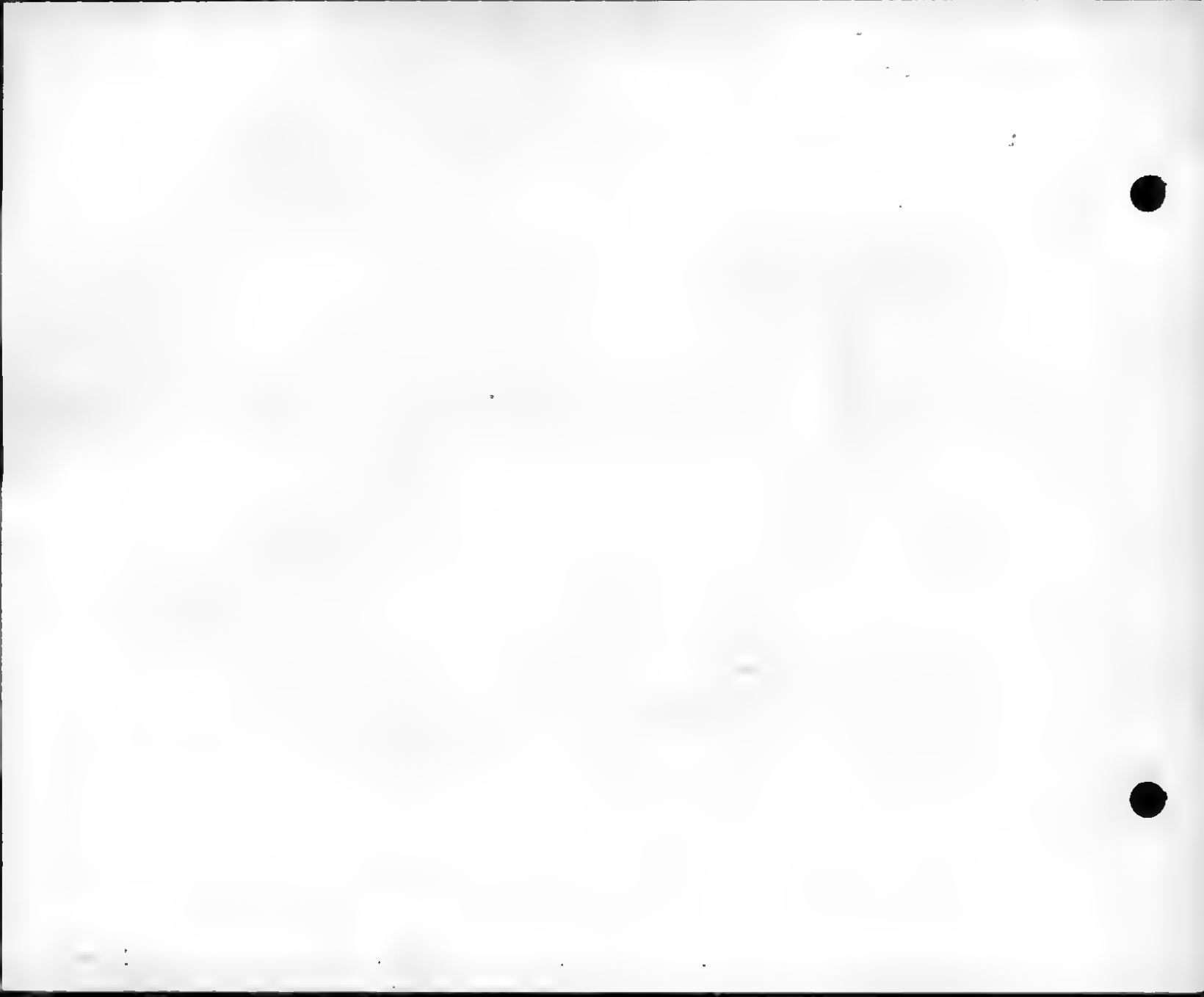
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15528

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (Type or print) Margurite L. Diehl | | | 2a. DATE OF DEATH 11 Month 9 Day 6 Year | | | 2b. HOUR 1:10 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 10-9-04 | | 6. AGE (in years last birthday) 64 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH Millersville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sto. Co. Gen. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Alto | | 13c. CITY OR TOWN Millersville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 3507 Eagle Lane | | 14. FATHER'S NAME First Middle Last John Diehl | | 15. MOTHER'S MAIDEN NAME First Middle Last XXXXXX Louise Fremin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 215509233 | | 17. INFORMANT Address Mr. John O'Neill-100 Malvern Ave. #4 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS, RIGHT 4177 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT. 27 , 19 68 , to NOV. 6 , 19 68 , that (I) (we) last saw the deceased alive on NOV. 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Fausto Q. Aquino Jr. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO JR. | | | | 22e. ADDRESS BALTO. COUNTY GEN. HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

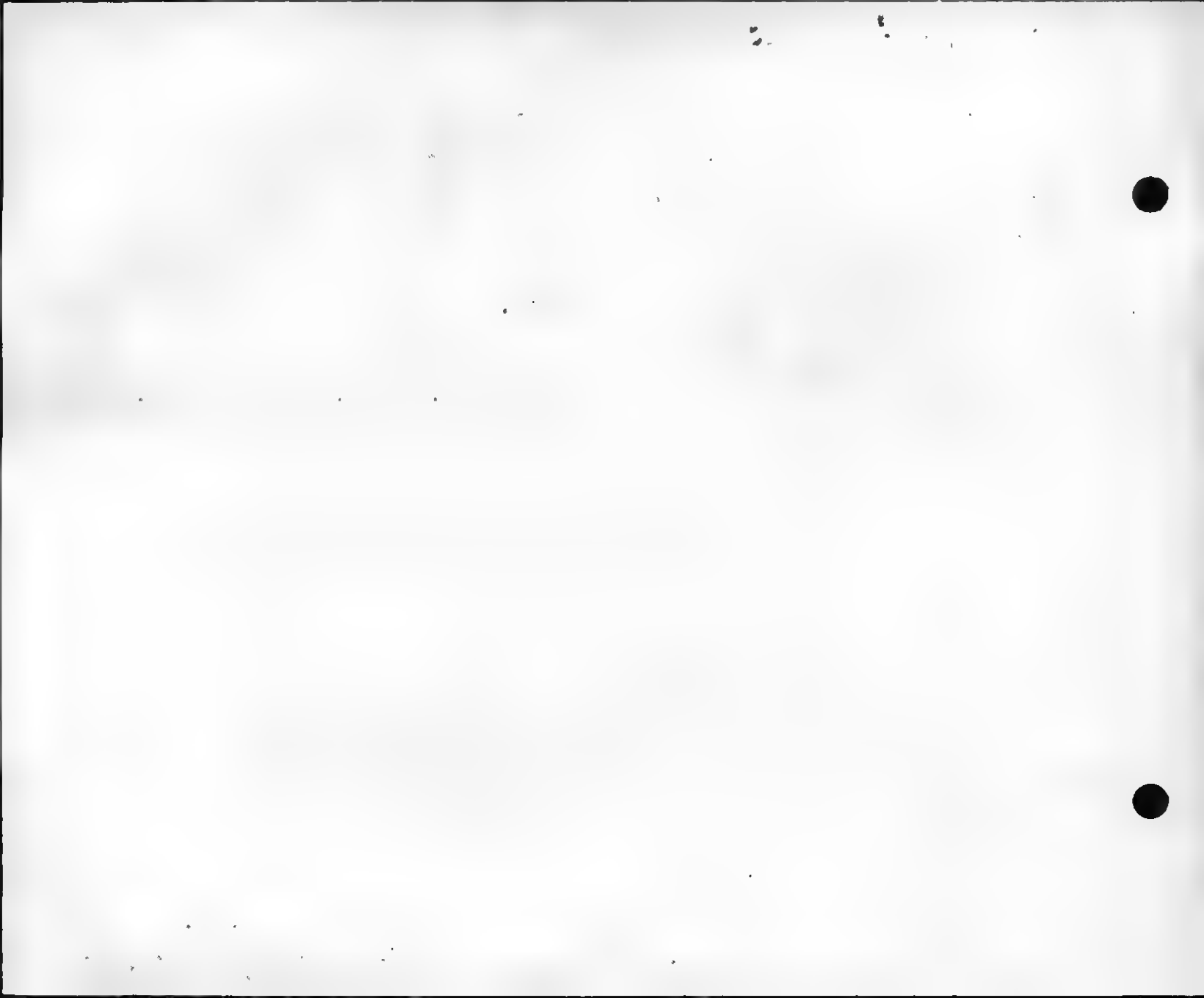
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15517

15529

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|---|---|--|
| 1. DECEASED-NAME (Type or print) Ada T Dietz | | | 2a. DATE OF DEATH Month 11 Day 4 Year 68 | | | 2b. HOUR M | | | | | |
| 3. SEX F | | 4. RACE WHITE | | 5. DATE OF BIRTH 12-18-1890 | | 6. AGE (In years last birthday) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MD | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 401 Edsdale Rd | | |
| 14. FATHER'S NAME First Middle Last Robert Scott Jones | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sully BALL Jones | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Williar P. Stumpf, 1911 Branston Rd., 21228 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pernicious Anemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan , 19 60 , to Nov 4 , 19 68 , that (I) (we) last saw the deceased alive on 11/1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE James J. Nolan | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11/4/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) James J. Nolan | | | | | | 22e. ADDRESS 1 Mallow Hill Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229 | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles J. J. | | | |

MEDICAL CERTIFICATION

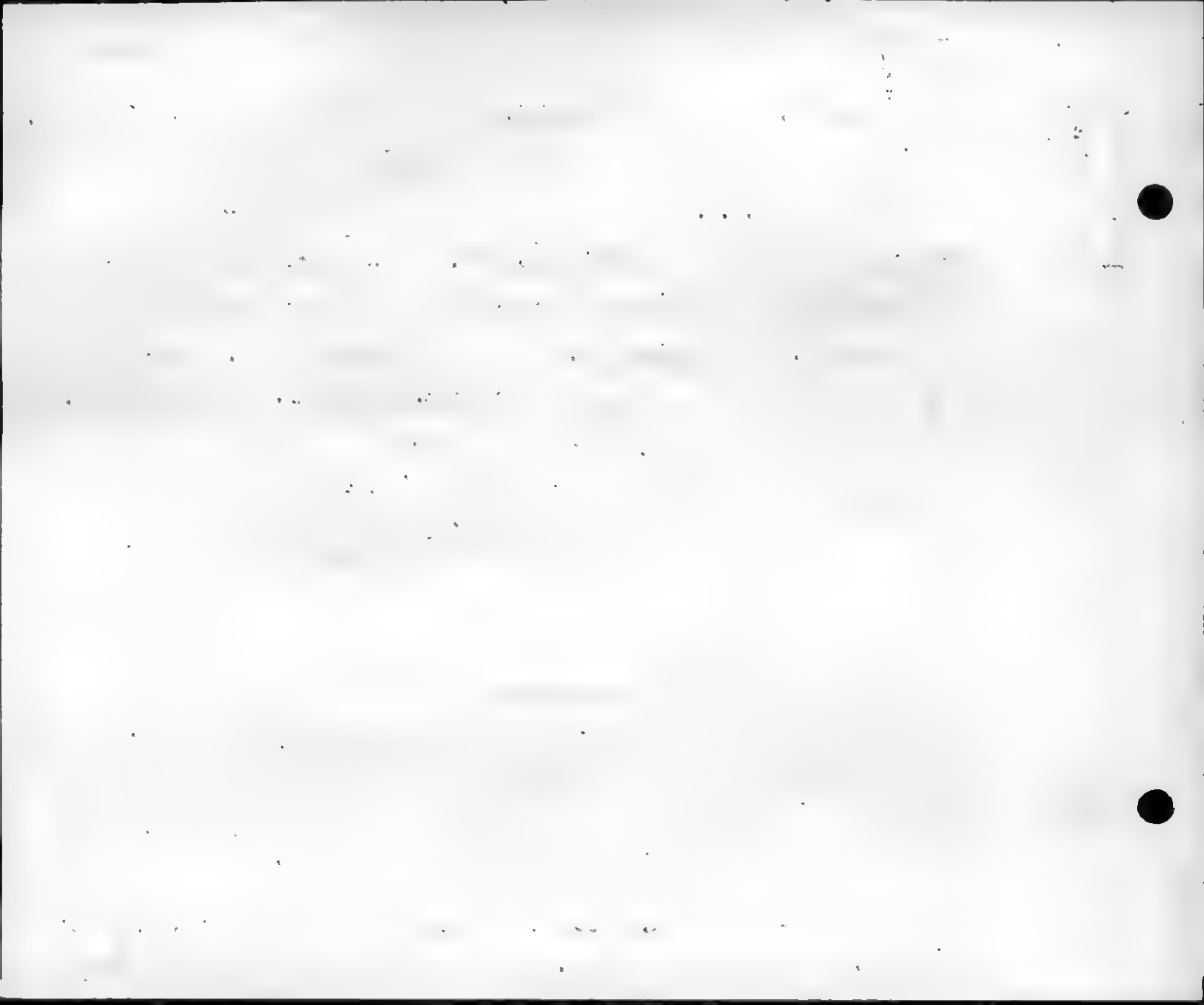


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Joseph M.</i> | | | First Middle Last <i>Dominick II</i> | | | 2a. DATE OF DEATH Month <i>11</i> - Day <i>7</i> - Year <i>68</i> | | | 2b. HOUR <i>2 A.</i> M. | | |
| 3. SEX <i>Male</i> | | | 4. RACE <i>White</i> | | | 5. DATE OF BIRTH <i>12-10-48</i> | | | 6. AGE (In years last birthday) <i>19</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Rosedale</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2322 Holyoke Rd.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Never Worked</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUA. RES. (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY <i>Baltimore</i> | | | 13c. CITY OR TOWN <i>Rosedale</i> | | | 13d. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last <i>Joseph M. Dominick Jr.</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Frances M. Massan</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. <i>None</i> | | |
| 17. INFORMANT <i>Joseph M. Dominick Jr.</i> | | | Address <i>2322 Holyoke Rd.</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> 742X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General Convulsions</i> (c) <i>Hypertrophied heart + Pneumonia</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 752X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Med Center</i> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/5</i> , 19 <i>66</i> to <i>11/5</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>John Geldrich</i> | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <i>11/7/68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Rosedale Med Group</i> | | | 22e. ADDRESS <i>8019 Philad Rd</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE <i>11-11-68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore City, Maryland</i> | | |
| 24. FUNERAL DIRECTOR <i>Philip E. Covich</i> | | | ADDRESS <i>1211 Chesaco Ave.</i> | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 12 1968</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



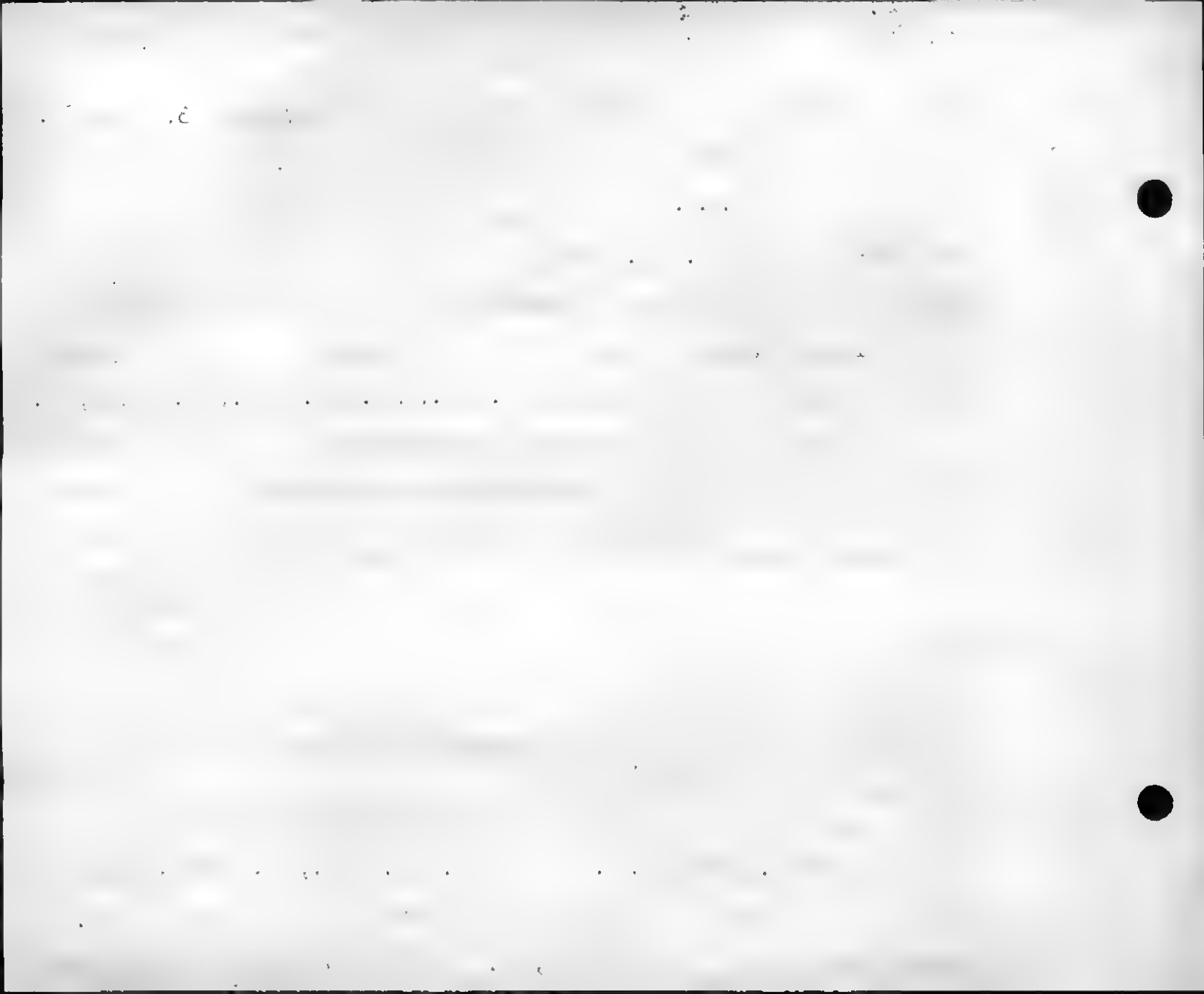
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A
45M

| 15519 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15531 | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|---|--|-----------------------|--|--|--|--|--|----------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| HENRY EDWARD DOYLE | | | | | | | | | | Month NOVEMBER Day 3, Year 1968 | | | | | | | | | | 3:20 a. M. | | | | | | | | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | 7 UNDER 1 YEAR | | | IF UNDER 24 HRS | | | | | | | | | | | | | | |
| MALE | | | WHITE | | | 11 13 08 | | | 59 | | | MONTHS | | | DAYS | | | HOURS | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | U.S.A. | | | | | | BALTIMORE | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| FORT HOWARD | | | VET. ADM. HOSPITAL | | | MACHINE OPERATOR | | | | | | | | | | | | | | | | | | | | | | | |
| 13a U.S. RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| MARYLAND | | | CARROLL | | | WESTMINSTER | | | | | | STONE ROAD | | | BOX 285 | | | ROUTE #1 | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| WILLIAM JOHN DOYLE | | | | | GERTRUDE MILLER | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b SOCIAL SECURITY NO | | | | | 17 INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| YES | | | | | WW-11 | | | | | 218 07 6693 | | | | | CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, LEFT LOWER LOBE | | | | | | | | | | 1 WEEK | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) CONGESTIVE HEART FAILURE (COR PULMONALE) | | | | | | | | | | MONTHS | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) CHRONIC PULMONARY EMPHYSEMA | | | | | | | | | | YEARS | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 28, 1968, to November 3, 1968, that (I) (we) last saw the deceased alive on November 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 11 3 68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| MARIO J. QUIROS, M. D. | | | | | | | | | | VET. ADM. HOSP., FT. HOWARD, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| BURIAL | | | | | 11-6-1968 | | | | | Holy Redeemer Cemetery | | | | | Baltimore City Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| LASSHAN FUNERAL HOME, | | | | | | | | | | 4401 S. Belair Road Baltimore, Md. | | | | | | | | | | NOV 7 1968 Charles Judge | | | | | | | | | |

MEDICAL CERTIFICATION

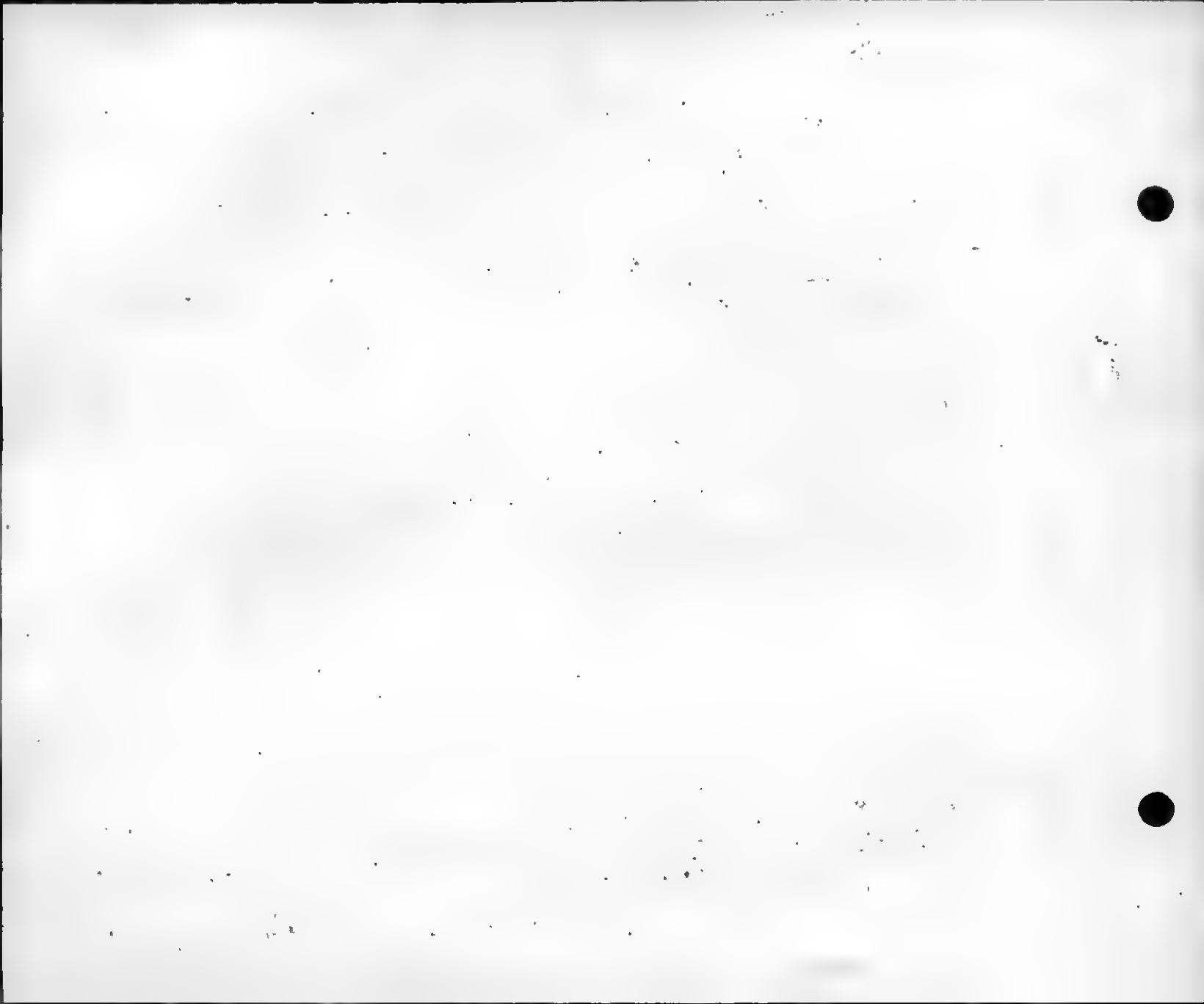


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 15520 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Emma H. Dressch</i> | | | | | | First <i>Emma</i> Middle <i>H.</i> Last <i>Dressch</i> | | 2a. DATE OF DEATH Month <i>11</i> Day <i>17</i> Year <i>68</i> | | 2b. HOUR <i>11:5</i> A M | |
| 3 SEX <i>F</i> | | 4 RACE <i>W</i> | | 5. DATE OF BIRTH <i>8-7-1888</i> | | 6 AGE (In years last birthday) <i>80</i> YRS. | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>BALTIMORE</i> Md | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Fron / Lehigh</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Anna Cost Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i> | | 13b. COUNTY <i>BALT-6</i> | | 13c. CITY OR TOWN <i>BALT-6</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>6802 Beach Ave</i> | | | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>Snyder</i> Last <i></i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Trumper</i> Last <i></i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO <i>216-01-3988</i> | | 17. INFORMANT <i>Mrs. Wilson</i> | | 17. INFORMANT Address <i>Margaret Wilson 6316 Marquette Ave</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1519</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>11-20-68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>11</i> Day <i>16</i> Year <i>1968</i> P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | | |
| 22a. I certify that <i>(4)</i> (this hospital) attended the deceased from <i>9/27</i> , 19 <i>68</i> , to <i>11-68</i> , 1968, that <i>(4)</i> (we) last saw the deceased alive on <i>11-16</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard Maffezzoli, M.D.</i> | | | | | | DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>11-17-68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>RICHARD MAFFEZZOLI</i> | | | | | | 22e. ADDRESS <i>1500 Willow Ave BALT 21204</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11-20-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Cemetery</i> | | 23d. LOCATION (City or Town) <i>Fullerton</i> (County) <i>Balto.</i> (State) <i>MD</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Lassahn Funeral Home 7401 Belair Road 21236</i> | | | | | | 25a. REC'D BY REGISTRAR <i>NOV 21 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

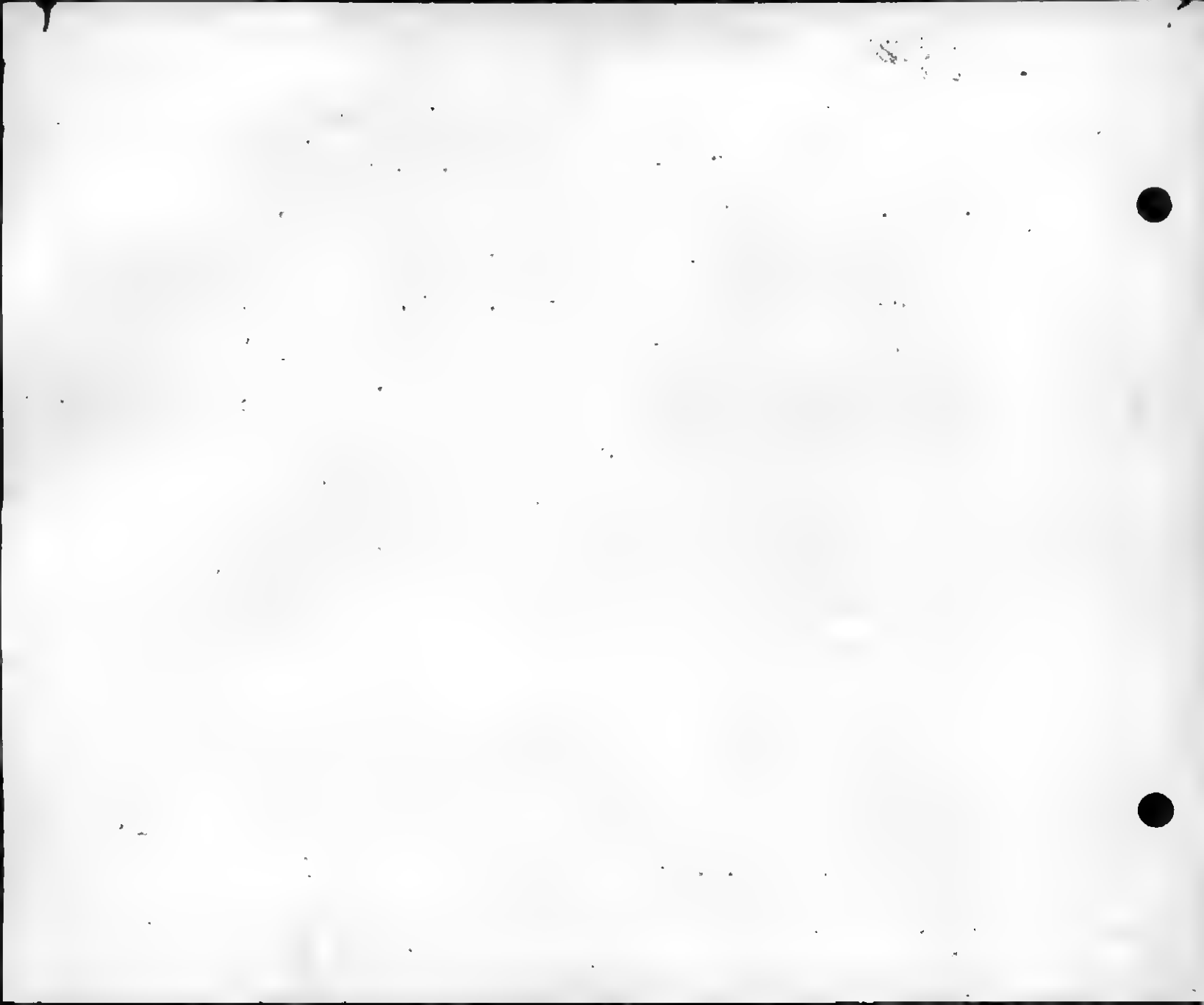


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

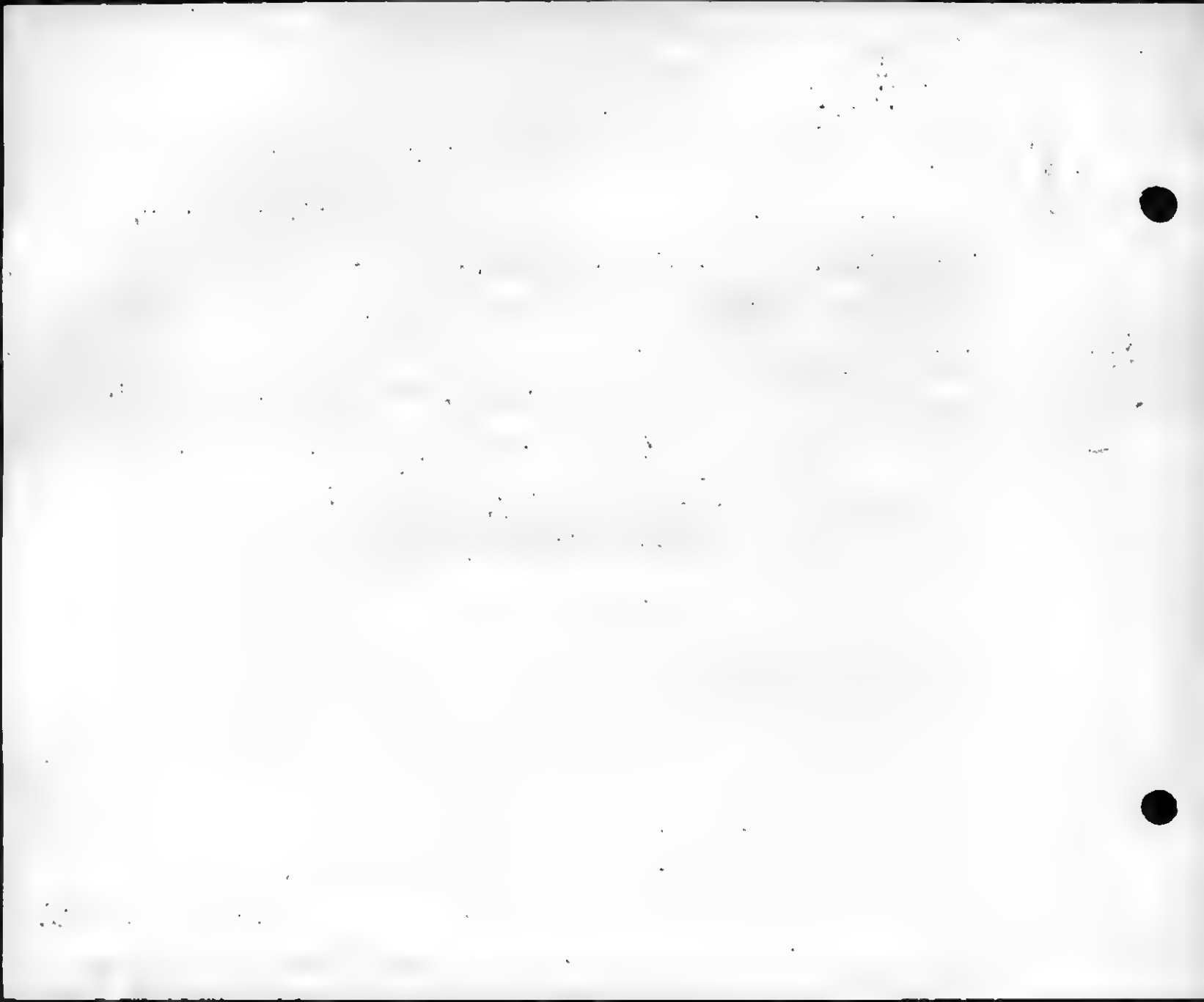
| MIDDLE | | | | | | | | | | LAST | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|
| DECEASED-NAME (Type or print) | | | | | | | | | | First | | | | | | | | | | Middle | | | | | | | | | | Last | | | | | | | | | | Month | | | | | | | | | | Day | | | | | | | | | | Year | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN | | | | | | | | | |
| 15522 | | | | | | | | | | CHRISTINE | | | | | | | | | | ANN | | | | | | | | | | EDELMANN | | | | | | | | | | November | | | | | | | | | | 9 | | | | | | | | | | 1968 | | | | | | | | | | | | | | | | | | | | 10:58 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | 7. UNDER 1 YEAR | | | | | | | | | | 8. UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | Aug. 29, 1966 | | | | | | | | | | 2 | | | | | | | | | | YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Balto. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Towson | | | | | | | | | | St. Joseph's Hospital | | | | | | | | | | child | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Baltimore | | | | | | | | | | Balto. | | | | | | | | | | | | | | | | | | | | 5649 Leiden Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bernard | | | | | | | | | | Edelman | | | | | | | | | | Monica | | | | | | | | | | Ambot | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | None | | | | | | | | | | Monica Edelmann | | | | | | | | | | 5649 Leiden Road. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | IMMEDIATE CAUSE (a) Hepatic insufficiency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (b) Biliary atresia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jose A. Aguto | | | | | | | | | | 11-9-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dr. Jose A. Aguto | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 11-12-68 | | | | | | | | | | Gardens of Faith Church | | | | | | | | | | Baltimore Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Philip F. Cuch | | | | | | | | | | 1211 Chesapeake Ave | | | | | | | | | | NOV 13 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 15522 | | | | | | | | | | | |
| 15522 | | | | | | | | | | | |
| 15522 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First FLETCHER | | | Middle COOPER | | | Last ELBEN | | |
| 3 SEX MALE | | | 4. RACE WHITE | | | 5 DATE OF BIRTH 12-2-91 | | | 2a. DATE OF DEATH Month NOV Day 27 Year 1968 | | |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore County, Md. | | |
| 10 CITY OR TOWN OF DEATH Mount Wilson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b COUNTY CAROLINE | | | 13c CITY OR TOWN RIDGELY | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME First WILLIAM | | | Middle ELBEN | | | 15 MOTHER'S MAIDEN NAME First HANNAH | | | Middle RASH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO. 218-12-1909 | | | 17 INFORMANT Address Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchitis + Bronchopneumonia</u> 1531 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of Transverse Colon - Resected</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1531 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-14-1968 to 11-27-1968, that (I) (we) last saw the deceased alive on 11-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. Newcomer | | | DEGREE M.D. | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE DEC 3, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT | | | 23d. LOCATION (City or Town) (County) (State) HILLSPOIR CAR. MD. | | |
| 24 FUNERAL DIRECTOR J. J. Moore & Son | | | ADDRESS Washington | | | 25a. REC'D BY REGISTRAR DA DEC 12 1968 | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |



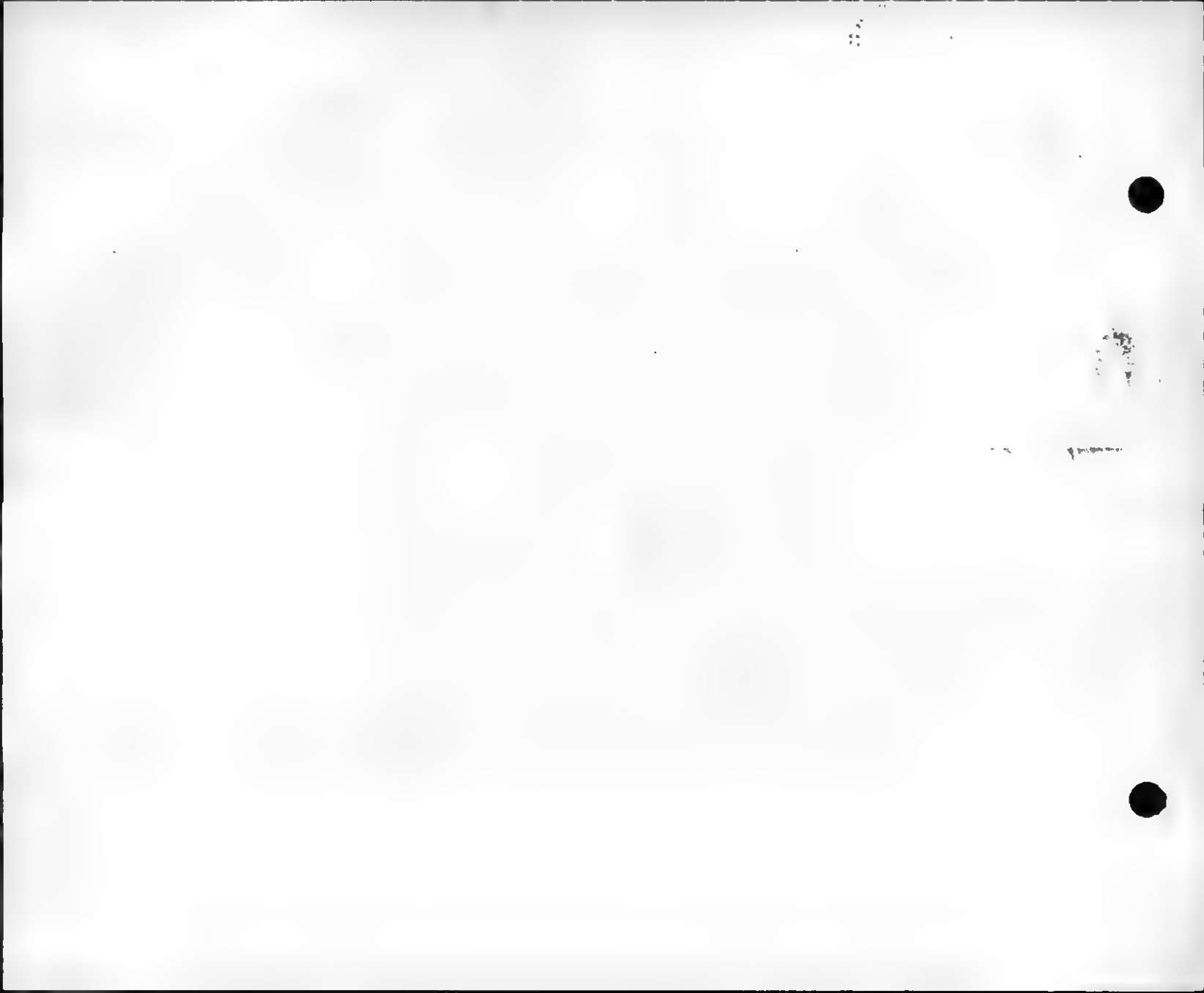
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|-------------------------------|--|--|
| 15522 | | 15530 | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last DAVID W. EVERTS | | | | | | 2a DATE OF DEATH Nov Month 16 Day 1968 | | | 2b. HOUR M | | | |
| 3 SEX M | | 4. RACE W | | 5 DATE OF BIRTH MAY 29, 1896 | | | 6. AGE (In years last birthday) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) CONN. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTO. | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH ARBUITS MD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 122 WAELCHLI AVE. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MECHANIC | | | 12b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN ARBUITS | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 122 WAELCHLI AVE. | | | |
| 14 FATHER'S NAME First Middle Last William F. EVERTS | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Bessie BARTLE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) YES WWI | | | 16b. SOCIAL SECURITY NO. 218-32-4483 | | 17 INFORMANT WM. F. EVERTS | | | Address 1402 SUMMIT AVE. #28 | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Arrhythmia 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Degeneration + Coronary DUE TO, OR AS A CONSEQUENCE OF (c) Artery Disease due to arteriosclerosis | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19, 1968 to Nov 16, 1968, that (I) (we) last saw the deceased alive on 18 Nov. 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE William J. Bryson MD | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 18 Nov 68 | | |
| 22d. PHYSICIAN'S NAME (Type) William J. BRYSON | | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 11/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Menden Ridge Cem | | | 23d. LOCATION (City or Town) (County) (State) Howard Co MD | | | | |
| 24. FUNERAL DIRECTOR E.S. MacNabb | | | | | | ADDRESS 301 Frederick Rd 21228 | | | 25a. REC'D BY REGISTRAR DATE NOV 20 1968 | | 25b. REGISTRAR'S SIGNATURE Wm. B. Nudge | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

15524

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15536

| | | | | | | |
|--|---|--|--|--|--|---|
| 1 DECEASED-NAME (Type or print) Elzie | | First O. | Middle FANSLER | Last | 2a DATE OF DEATH Month November Day 21 Year 1968 | 2b HOUR 6:35 P |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH 2-11-11 | | 6 AGE (In years lost birthday) 57 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS HOURS 0 MIN 0 |
| 7a BIRTHPLACE (State or foreign country) Idaho | 7b CITIZEN OF WHAT COUNTRY? U.S. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH Baltimore Md. | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | 12a USUAL OCCUPATION (Kind of work done during major working life) Perma. Railroad | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland | 13b COUNTY Baltimore | 13c CITY OR TOWN Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER 1016 Iris Avenue #21205 | | |
| 14 FATHER'S NAME First Isaac Middle Fansler Last Fansler | | 15 MOTHER'S MAIDEN NAME First Ida K. Middle Netherland Last Netherland | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO. 717-07-6896 | | 17. INFORMANT Mrs. Celeste Fansler Address (Same) | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac tamponade 4104 DUE TO, OR AS A CONSEQUENCE OF (b) rupture of the myocardium DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | |
| 22a I certify that St (this hospital) attended the deceased from 11-1-68 , 19 68 , to 11-21- , 19 68 , that I (we) last saw the deceased alive on 11-21-68 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (aid) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Cilliani | | 22c. DATE SIGNED 11-22-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | 22e. ADDRESS 7620 York Road, Towson, Maryland 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11/26/68. | 23c. NAME OF CEMETERY OR CREMATORY St. Johnstown Cemetery | | 23d. LOCATION (City or Town) (County) (State) Greenwood, Delaware | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

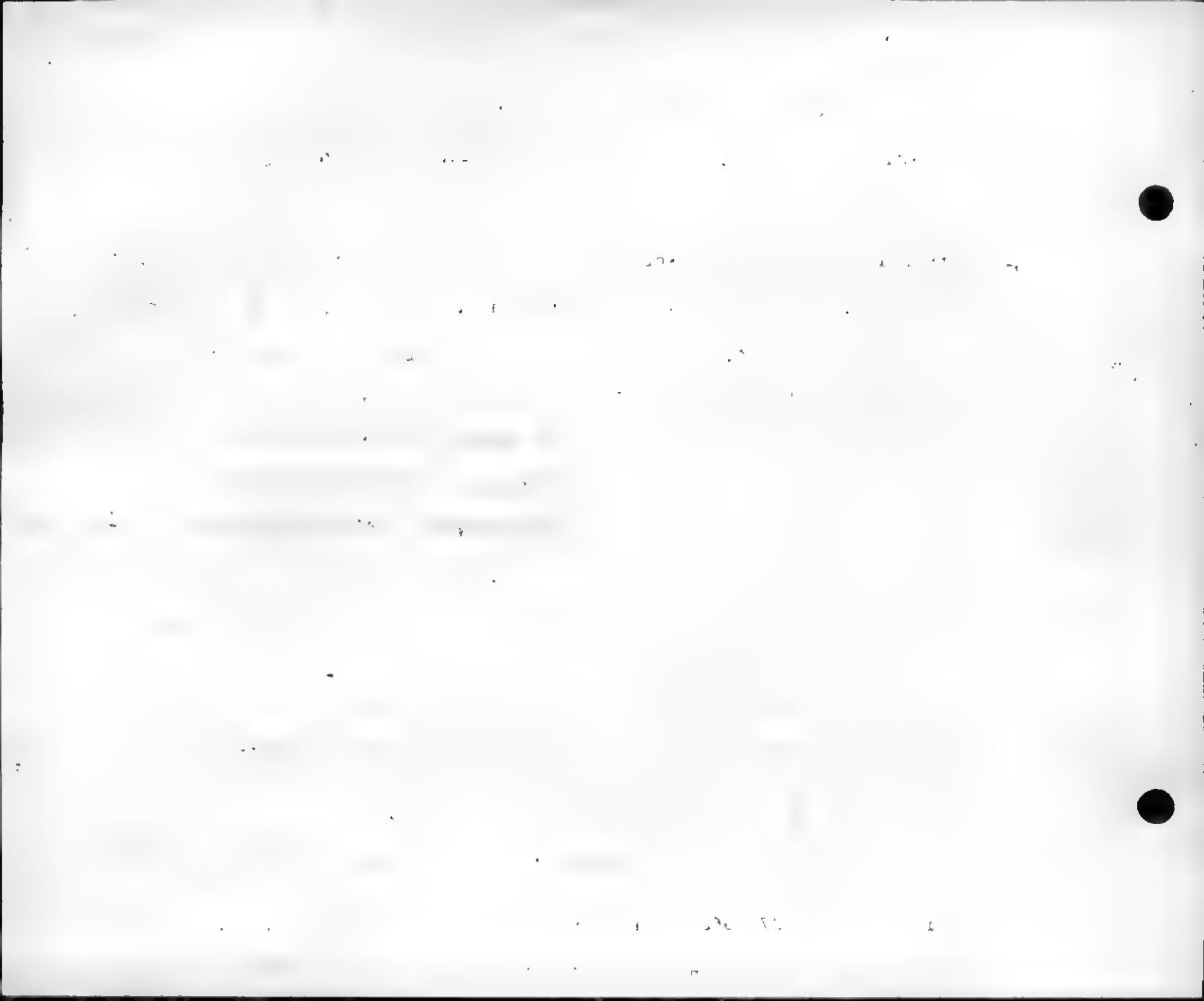
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15525

15525

| | | | | | | | | | |
|--|--|---|--|---|--|---|------------------------------|---|--|
| 1. DECEASED-NAME (Type or print) Francis Edward Farley | | | 2a. DATE OF DEATH Month 11 Day 25 Year 1968 | | | 2b. HOUR 2:45 M | | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH 11-16-1930 | | 6. AGE (In years last birthday) 38 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS Min | |
| 7a. BIRTHPLACE (State or foreign country) Balto. | | 7b. CITIZEN OF WHAT COUNTRY? Usa | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Balto. Md. | | | |
| 10. CITY OR TOWN OF DEATH Lutherville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fallscroft Way | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Medical Doctor | | 12b. KIND OF BUSINESS OR INDUSTRY Medicine | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Lutherville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Box 142 Fallscroft Way | |
| 14. FATHER'S NAME First Middle Last John A. Farley | | | 15. MOTHER'S MAIDEN NAME First Middle Last Pauline Kohlerman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes Korean War | | 16b. SOCIAL SECURITY NO 213-26-9680 | | 17. INFORMANT DorothyX Farley, Wife | | | Address Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF CARDIAC INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CORONARY ARTERIOSCLEROSIS (b) (c) 4 weeks. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-27-1968 to Nov 24, 1968 , that (I) (we) lost the deceased alive on 11-18-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Keith A. Manley | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11.25.68 | | | |
| 22d. PHYSICIAN'S NAME (Type) KEITH A. MANLEY | | 22e. ADDRESS 2045, YORK ROAD, TIMONIAH | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-27-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION (City or Town) (County) (State) Texas, Md. | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks T wson, nc. | | ADDRESS Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |



FOR STATE
HEALTH DEPT.

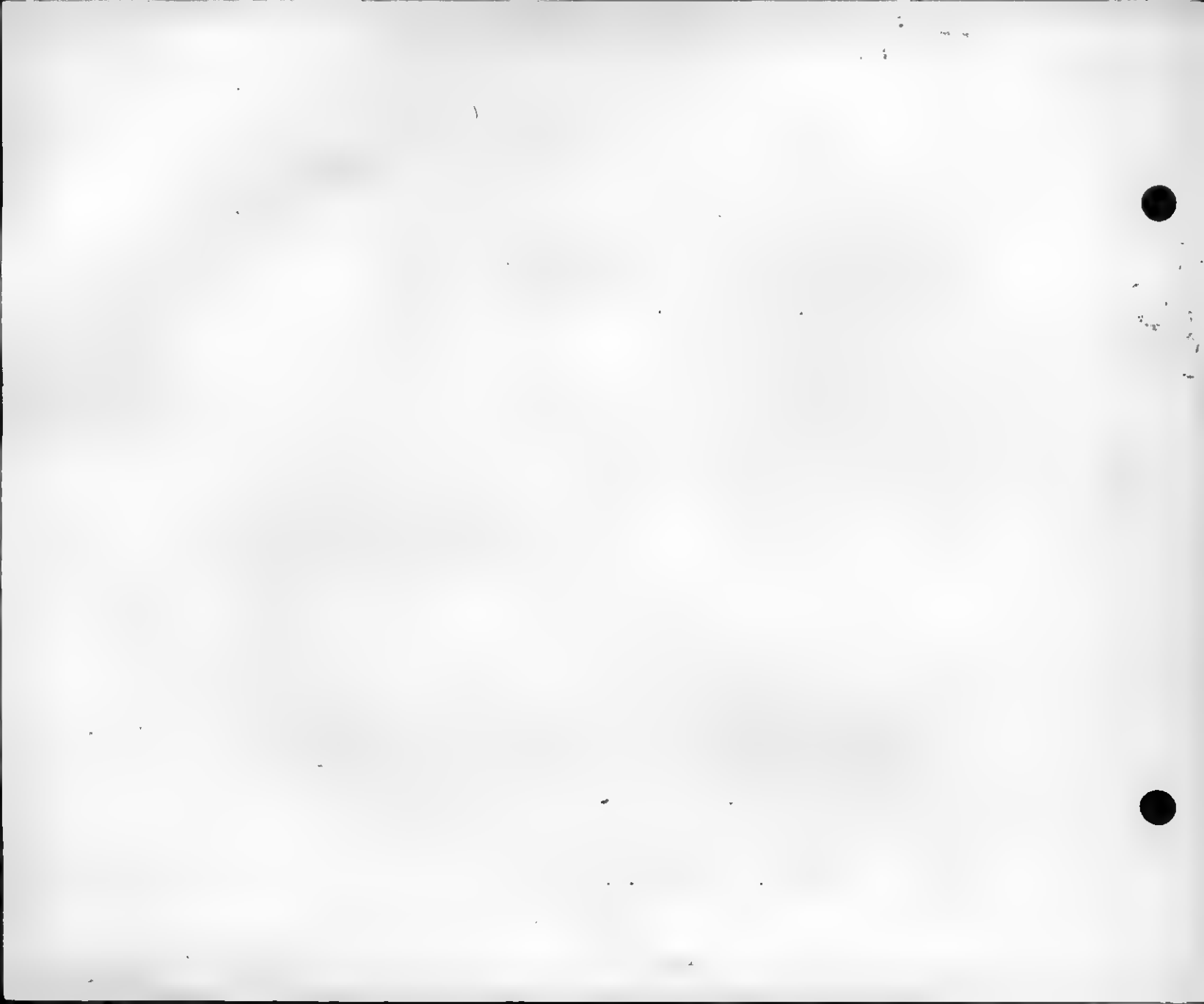
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15528

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15538

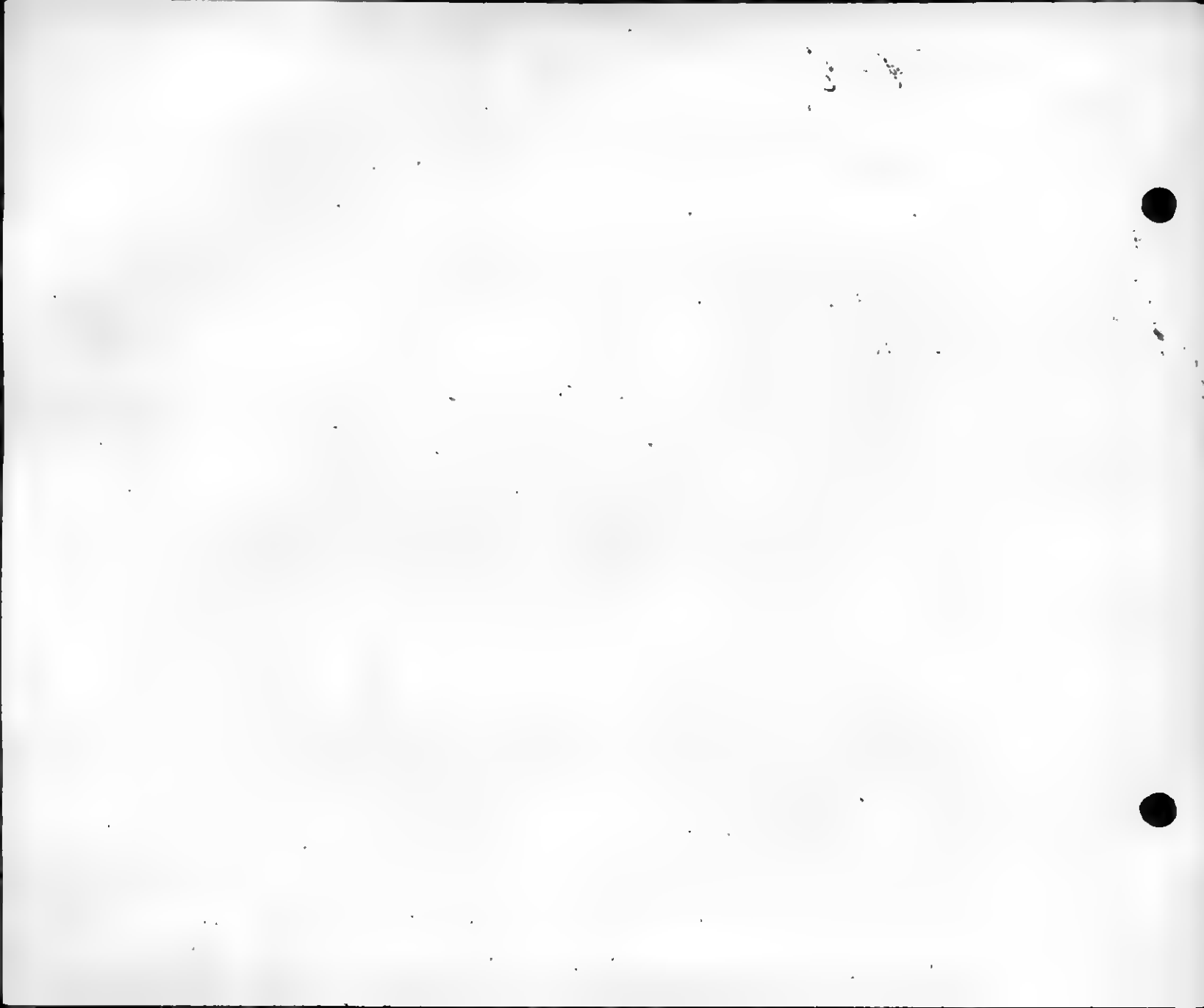
| | | | | | | | | | | | | | | |
|--|--------|-----------------|--|--|-----------------|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | |
| ETHEL ADA FAUST (Faust) | | | | | | 11 23 19 68 | | | 1:30p | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | 7 MOER 1 YEAR | 8 UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | Month Day Year | | | 2d. HOUR | | |
| Female | White | 6/22/30 | 38 YRS | | | November 23, 19 68 | | | 1:30p | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | | USA | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Balto. | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Catonsville | | | 937 South Ridge Rd. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Md. | | | Balto. | | | Catonsville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 937 South Ridge Rd. | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | |
| William B. Heying | | | | | | Leila ROSENSTEEL | | | Leila Rosensteel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 217-24-3049 | | | Robert P. Faust | | | Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Asphyxia in plastic bag | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| CAUSE OF DEATH | | | | ? P.M. 11 23 19 68 | | | | Subject tied plastic bag over head | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | | | Home | | | | 937 South Ridge Rd. Catonsville Balto. Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) | | | | Edward F. Wilson, M.D. | | | | ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | |
| Burial | | | | 11/27/68 | | | | Baltimore National | | | | | | |
| | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| | | | | | | | | Catonsville, Md | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | | | |
| Wm. Cook-Brooks Westminster Balt. Md. 21228 | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| | | | | | | | | Nov. 24, 1968 | | | | | | |
| | | | | | | | | Charles Judge | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

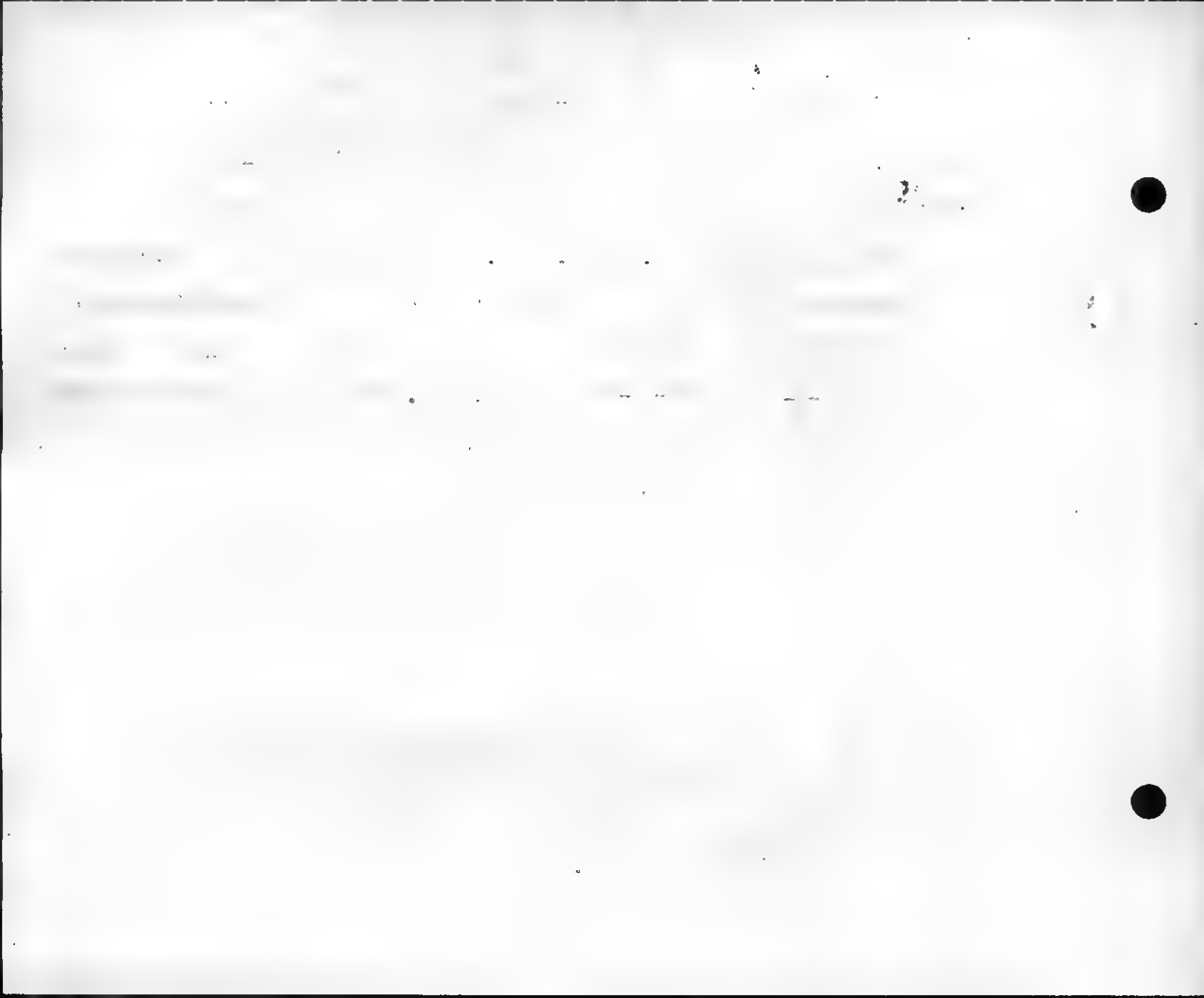
| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|-----------------------------|---|--|---------------------------------------|--|---|--|---|---|------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 15527 CERTIFICATE OF DEATH 15539 | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M | | | |
| Ella | | | Finagin | | | November 23 1968 | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| female | | white | | Aug. 12, 1880 | | | 88 YRS. | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | | |
| Md. | | U. S. | | | | Baltimore | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | housewife | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | | Anne Arundel | | el Annapolis | | | | 1207 President Street | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| John W. Thomas | | | JOSEPH G. GRIFFITH | | | ANNE BAKER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | | | |
| NS | | | 219-54-3116T | | RRECORDS: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | | | | | | | | | Days | | |
| +134 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> | | | | | | | | | | Years | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | |
| 7 + 100 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | County State | |
| | | | | | | | | | | | | |
| 22a. I certify that at (this hospital) attended the deceased from <u>April 9</u> , 19 <u>62</u> , to <u>Nov 23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | |
| <u>George Rodou</u> | | | 11-23-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| George Rodou | | | SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | | NOV. 26, 1968 | | BETHGSDA CHURCH | | PRESTON | | CAR. | | MD. | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | |
| CHARLES V. MOORE | | | BENTON, MD | | DATE NOV 27 1968 | | <u>Charles Judge</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

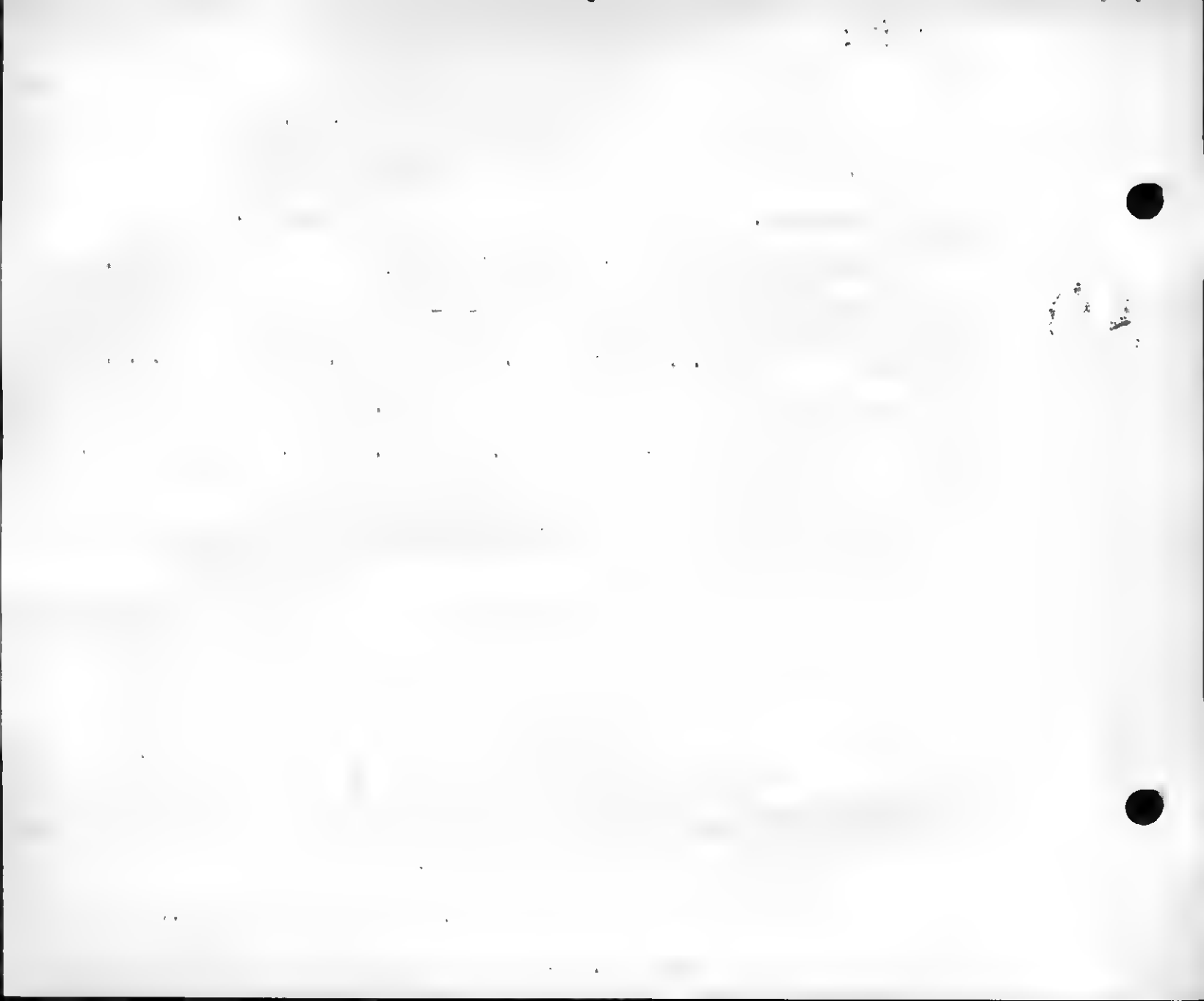
| 1 DECEASED NAME (Type or print) | | First | Middle | Last | 2a DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|----------------------------------|--|
| CONRAD ANDREW FISCHER | | | | | 11 Month 22 Day 68 Year | 6:35 PM |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| MALE | CAUCASIAN | | 1/20/1899 | | 69 YRS | |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| BALTIMORE MD | USA | | | BALTIMORE Md | | |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | GREAT. BALT. MED. CEN. | | Restaurant | | Restaurant | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Res. dence before admission) STATE | 13b. COUNTY | 13c CITY OR TOWN | 13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER | | |
| Maryland | | Baltimore | | 2301 Westfield Avenue | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| Andrew | | Fischer | | Anne Long Ester | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | |
| | | 218-32-1016 | | Frances E. Fischer 2301 Westfield Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO GENIC SHOCK</u> | | | | | | ABOUT 2 DAYS |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | |
| (b) <u>PULMONARY EDEMA</u> | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a DATE OF OPERATION | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2:30PM 11-22-68 to 6:35PM 11-22-68, that (I) (we) lost the deceased alive on 11-22-19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | |
| 22b. SIGNATURE Neeraja Thaluk | | | | 22c DATE SIGNED 11-22-68 | | |
| 22d PHYSICIAN'S NAME (Type) NEERAJA THAKUR, M.D. | | | | 22e ADDRESS 6701 N CHARLES ST, BALT, MD | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) |
| Burial | | Nov 26 68 | | Parkwood Cemetery | | Taylor Ave Balto Md |
| 24. FUNERAL DIRECTOR THE DIPPEL BROS INC 7110 BELAIR RD | | | | 25a REC'D BY REGISTRAR DATE NOV 26 1968 | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11/12/68
15528
CERTIFICATE OF DEATH
15541

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Rosedale</u> , MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Rosedale</u> , b. COUNTY <u>Maryland</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, County</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u> | |
| c. LENGTH OF STAY IN 1b <u>75 years</u> | | d. STREET ADDRESS <u>1025 Chesaco Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1025 Chesaco Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM GPO FISCHER</u> | | 4. DATE OF DEATH Month Day Year <u>11 1st 19 68</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-18-83</u> |
| 9. AGE (In years last birth day) <u>75 85 s.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H.C. Weiskettle Co.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Conrad Fischer</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna B. Pfaff</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-09-7362</u> | |
| 17. INFORMANT <u>Mrs. Eleanor C. Willis</u> | | Address <u>1027 Chesaco Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>5 yrs</u> (c) <u>4201</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>11/1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> , 19 <u>68</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>G.M. Baumgardner</u> M.D. | | 22b. DATE SIGNED <u>11-1-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>G.M. BAUMGARDNER</u> | | 22d. ADDRESS <u>Balto 21237</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-5-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Evangelical L. Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Philip E. Cyach</u> | | 25a. REC'D BY REGISTRAR <u>1211 Chesaco Ave. #21237</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>NOV 4 1968</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers' Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| CHARLES | | | EMORY | | FISHER | | NOVEMBER 25, 1968 | | 7:30 PM | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | |
| MALE | | | NEGRO | | 1/23/95 | | 79 73 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| MARYLAND | | | U.S.A. | | | | BALTIMORE | | CONSTRUCTION | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | |
| FORT HOWARD | | | VETERANS ADMIN. HOSPITAL | | LABORER | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND | | | HOWARD | | MARRIOTTSTVILLE | | | | Rt 99B 125 | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| ELIAS | | | - | | FISHER | | RACHEL | | SEVOY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | |
| YES | | | WWI | | 218 12 33 36 | | CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF CEREBRAL HEMORRHAGE | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF CEREBRAL ARTERIOSCLEROSIS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | | |
| 331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO autopsy | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (this hospital) attended the deceased from OCT 15, 1968, to NOV 25, 1968, that (X) (we) last saw the deceased alive on NOV 25, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| Nan Ann Orer M.D. | | | | | | | | 11/26/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D. | | | | | | | | 22e. ADDRESS | | | |
| VAH, FT. HOWARD, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REBURY (Type) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | 11-24-68 | | BALTIMORE NATIONAL | | BALTIMORE, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| HAIGHT FUNERAL HOME | | | ROUTE 32, ELDERSBURG, SYKEVILLE, MD. | | DEC 2 1968 | | Charles Judge | | | | |

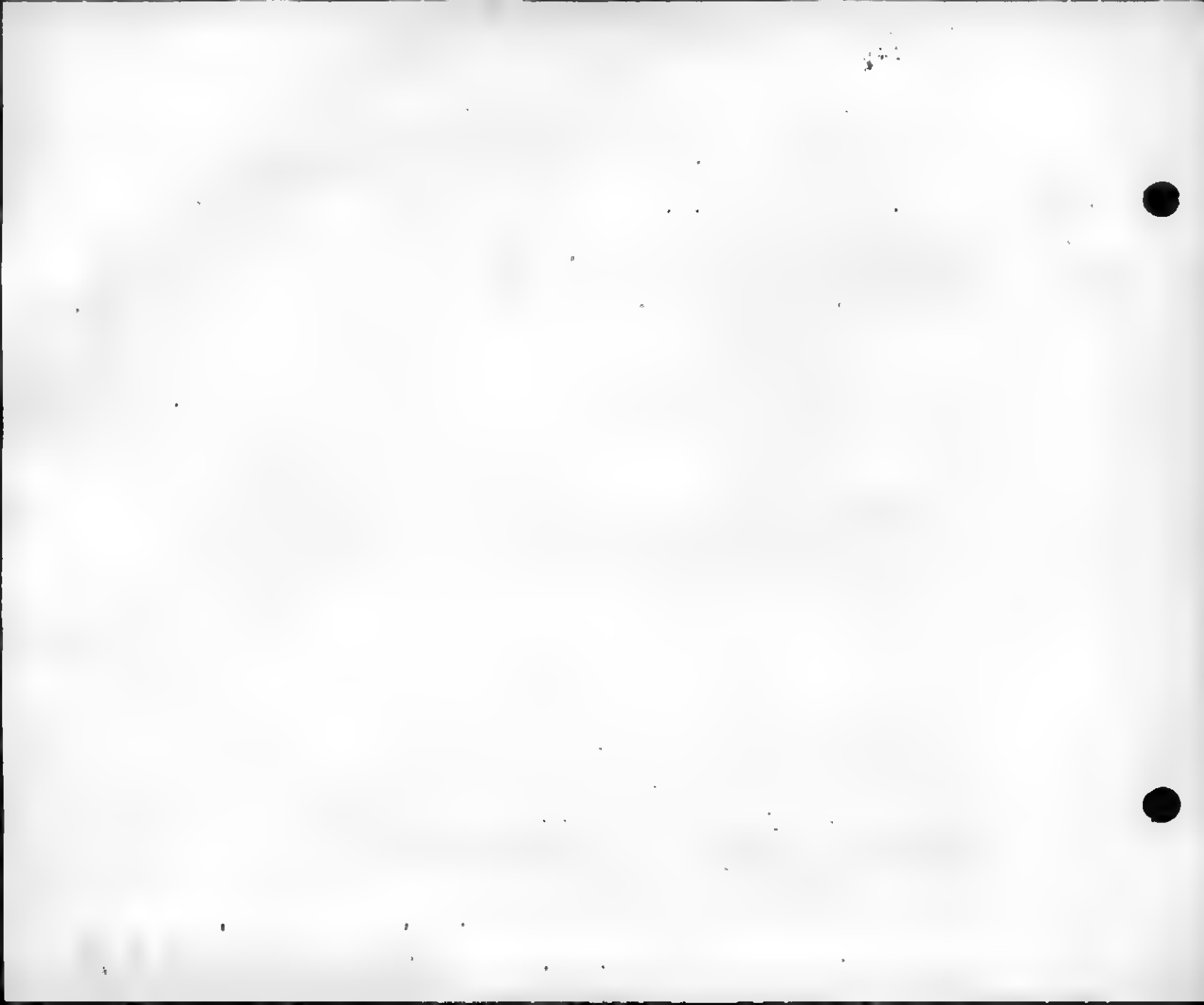


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 15532 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15543 | |
|--|---------|------------------|--|--|------|--|-----|--|--|--|------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| David Delmar Flower | | | | | | Month Day Year | | | 11 7 19 68 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| m | white | Jan. 13, 82 | 86 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | 11 7 19 68 |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Md. | | | U.S.A. | | | | | | Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | St. Joseph | | | | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | | Balto. | | | Balto. | | | 2601 Wentworth Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Robert Flower | | | unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | 217-05-0050 | | | Robert Atkin Sparks, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Sudden | |
| 4109 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4109 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| CAUSE OF DEATH | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | Charles F. O'Donnell, M.D. | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | | | 11/7/68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Entombment | | | | 11/11/68 | | | | Moreland Mem. Pl. Balto. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | |
| Leonard J. Ruck Inc. Balto. Md. | | | | | | | | NOV 8 1968 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | Charles Judge | | | |

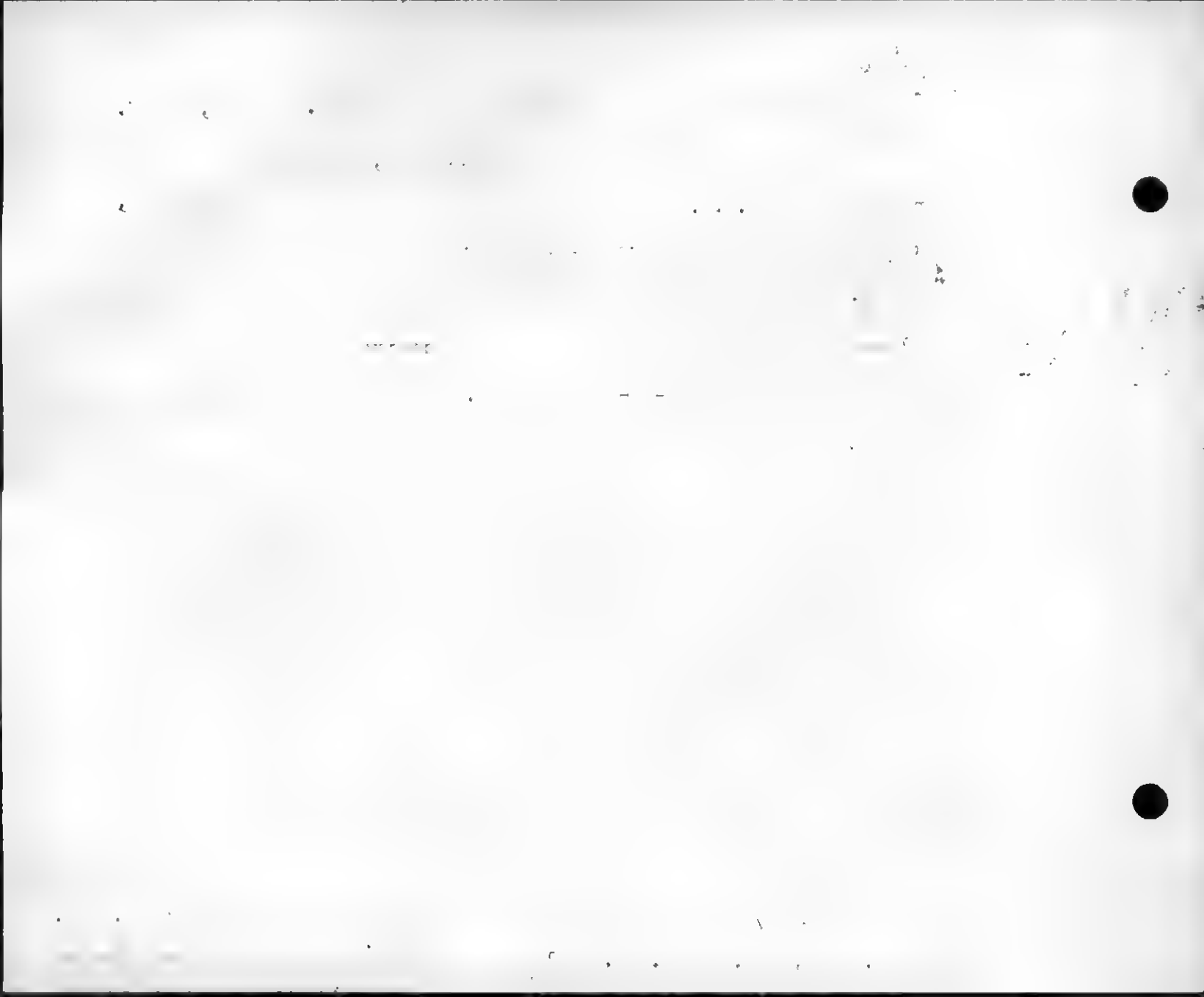


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (3-64)
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 15538 | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) THEODORE | | | First Middle Last FORNWALT | | | 2a. DATE OF DEATH Nov. Month 27, Day 1968 | | 2b. HOUR 9 A. M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH November 25, 1876 | | 6. AGE (In years last birthday) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, Md. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holly Hill Manor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baldwin | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Fork Road | |
| 14. FATHER'S NAME First Middle Last Peter Fernwalt | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lidia Stermer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 212-38-2367 | | 17. INFORMANT Mrs. C. Bernice Fernwalt | | Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4407 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1964 to Nov 27, 1968 , that (I) (we) last saw the deceased alive on Nov 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Laurence C. Post M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/27/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) LAURENCE C. POST | | | | 22e. ADDRESS 6805-York Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY Wilson United Methodist | | 23d. LOCATION (City or Town) (County) (State) Long Green Balto. Md. | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE NOV 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

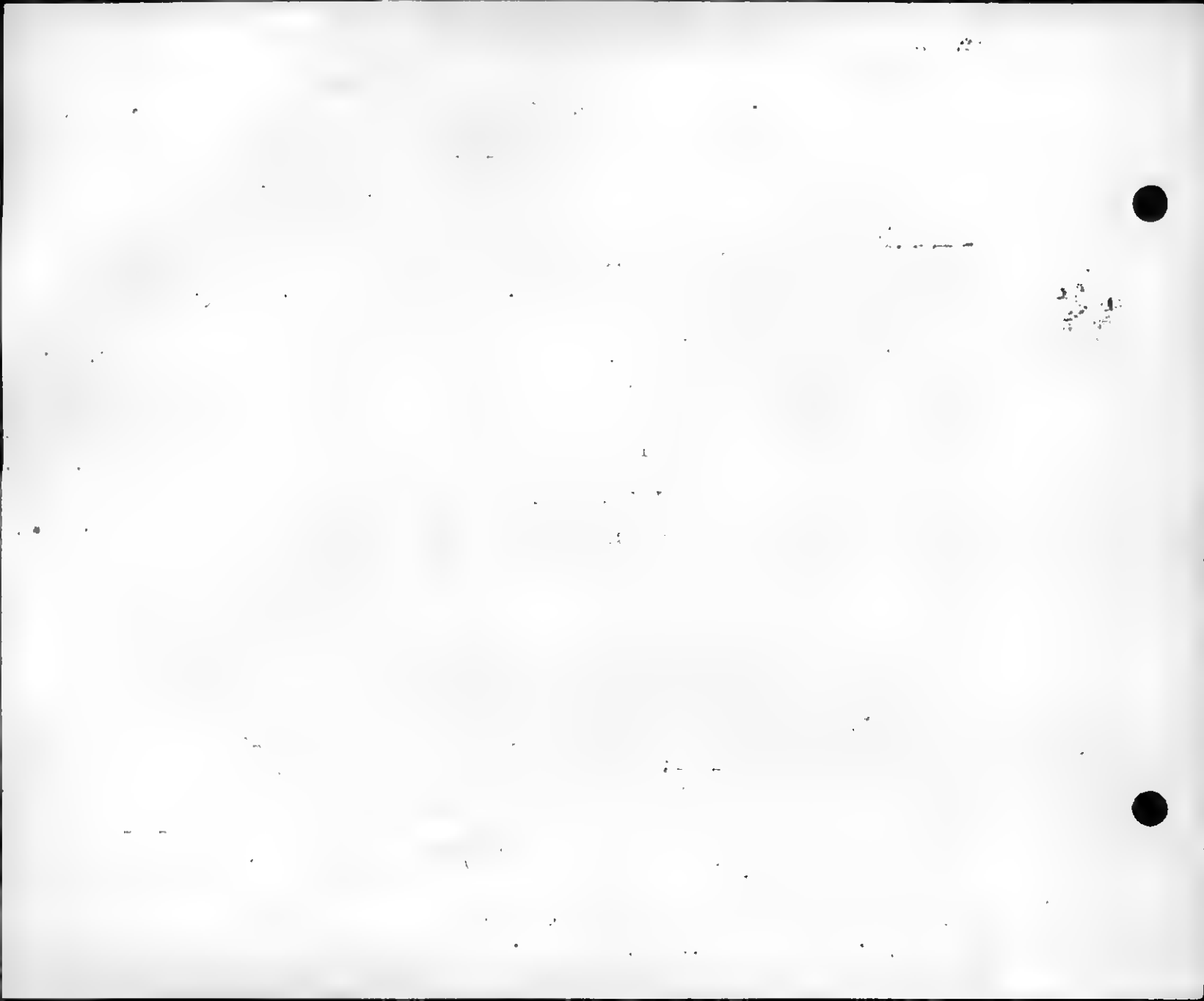
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15532

15545

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) ISADORE FRADKIN | | | 2a. DATE OF DEATH 11 Month 28 Day 68 Year | | | 2b. HOUR 9:05PM | | | |
| 3. SEX MALE | | 4. RACE CAU | | 5. DATE OF BIRTH 7-14-14 | | 6. AGE (In years last birthday) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH XXXXXX Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBALT. MED. CENTER | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>lawyer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1 DELL COURT | |
| 14. FATHER'S NAME First Middle Last NATAAN FRADKIN | | | 15. MOTHER'S MAIDEN NAME First Middle Last ANNIE FRADKIN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> | | (If yes give war or dates of service) <i>WW II</i> | | 16b. SOCIAL SECURITY NO 212-50-6432 | | 17. INFORMANT <i>Wife</i> | | Address <i>Same</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE <i>444</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPRETENSION RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY EDEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 YRS. HYPT. RENAL FAILURE 1 YR P. EDEMA 6MO. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)) <i>4444X</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-21 , 19 68 , to 11-28 , 19 68 , that (I) (we) last saw the deceased alive on 11-28-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Neeraja Thakur</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-29-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) NEERAJA THAKUR | | 22e. ADDRESS 6701 NORTH CHARLES STREET | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE 12/1/68 | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mukro Kodesh</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Balto Md</i> | | | |
| 24. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, Inc</i> | | | | ADDRESS <i>9610 Rustertown Rd</i> | | 25a. REC'D BY REGISTRAR DATE DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1/25

| <div style="display: flex; justify-content: space-between;"> 15534 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15546 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) | | | First Henry | | | Middle Palmer | | | Last FRANKENFIELD | | | 2a. DATE OF DEATH Month 11 Day 21 Year 1968 | | | 2b. HOUR 1:55 PM | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 7-3-1883 | | | 6. AGE (In years last birthday) 85 YRS | | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN 0 | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore, Md | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Executive | | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Lutherville | | | 13d. INS. OF CITY L.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 4 Bramleighgarth | | | | | |
| 14. FATHER'S NAME First John Middle Wesley Last Frankenfield | | | 15. MOTHER'S MAIDEN NAME First Sarah Middle Elizabeth Last Richmond | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (na, or unknown) <input type="checkbox"/> None <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO None | | | 17. INFORMANT Family records Address | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple pulmonary infarctions DUE TO, OR AS A CONSEQUENCE OF (b) Multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic pancreatitis | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/5/ , 19 68 , to 11/21/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/21/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Samuel Lee, M.D. | | | DEGREE | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 11/21/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D. | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition Buried | | | 23b. DATE Nov. 23, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Towson, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR John J. Burns | | | ADDRESS Towson, Md. | | | 25a. REC'D BY REGISTRAR NOV 26 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |



CERTIFICATE OF DEATH

| | | | | | | | | |
|---|------------------------------|--|--|--|--------------------------------|--|----------------------------------|--|
| 1 DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Charles | | H. | Frederick | | Nov. Month 22 Day 1968 Year | | M | |
| 3. SEX | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| M | W | | 9-18, 1880 | | 88 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Maryland | U. S. A. | | | | Baltimore | | B & O | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Halethorpe | | 1002 Francis Avenue 21227 | | Retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | |
| Maryland | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1002 Francis Avenue 21227 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | |
| Jacob | | Annie Margaret Dowling | | No | | | | |
| 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | | |
| | | Hattie Frederick 1002 Francis Avenue 21227 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 | | | | | | | | 71P |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1915, to Nov. 22, 1968, that (I) (we) last saw the deceased alive on July 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | 22d. ADDRESS | | 22e. DATE SIGNED | | |
| Frederick V. Beitler | | MED. DIRECTOR | | 1014 Francis Avenue | | 11/22/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. DATE SIGNED | | | | |
| Frederick V. Beitler | | 1014 Francis Avenue | | 11/22/68 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 11-25-68 | | Loudon Park Cemetery | | Baltimore City, Balto. Md. | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 24b. REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | |
| Howard H. Hubbard | | 4107 Wilkens Avenue 21229 | | NOV 25 1968 | | Charles George | | |

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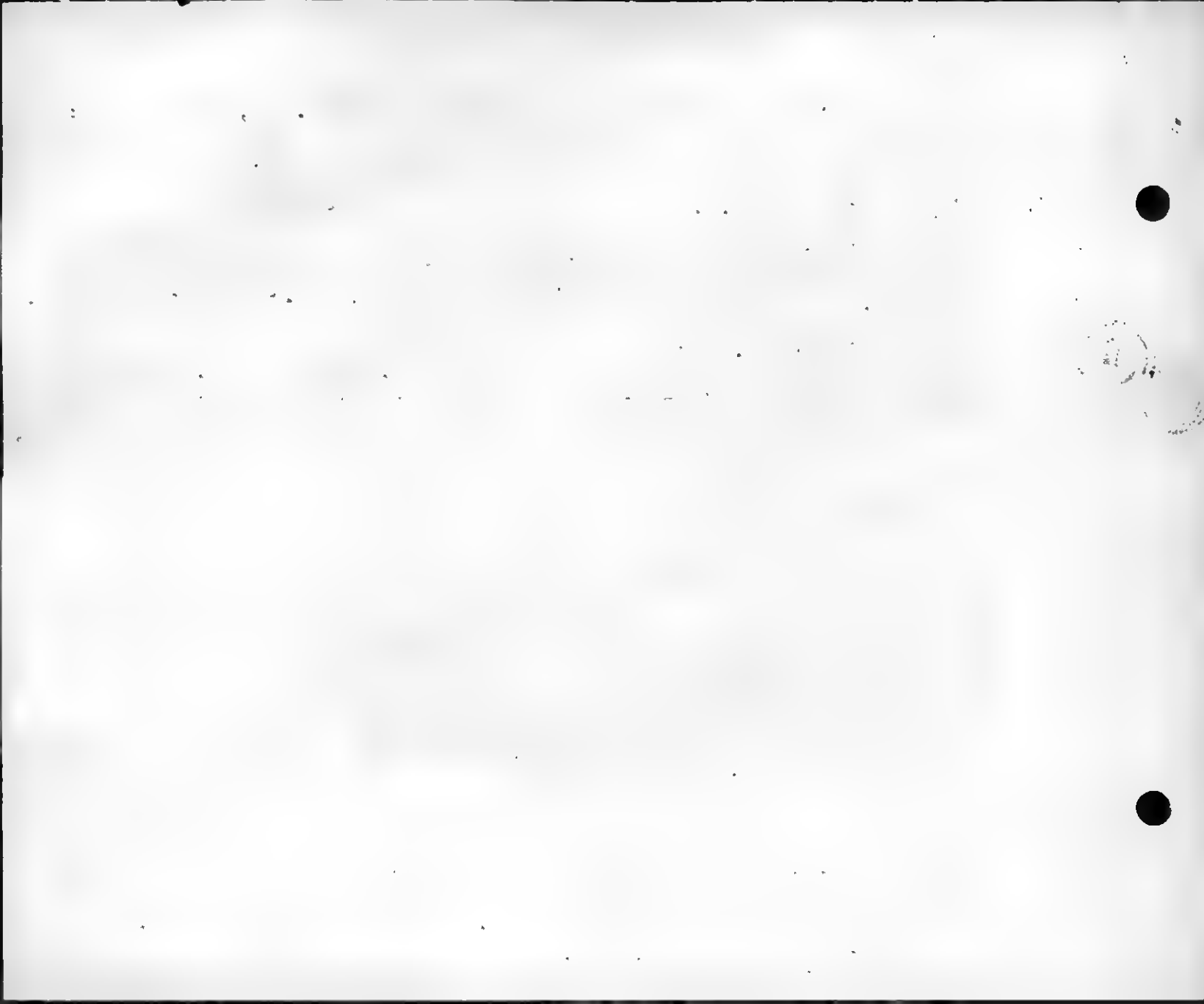


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514
30M REV. 1-68

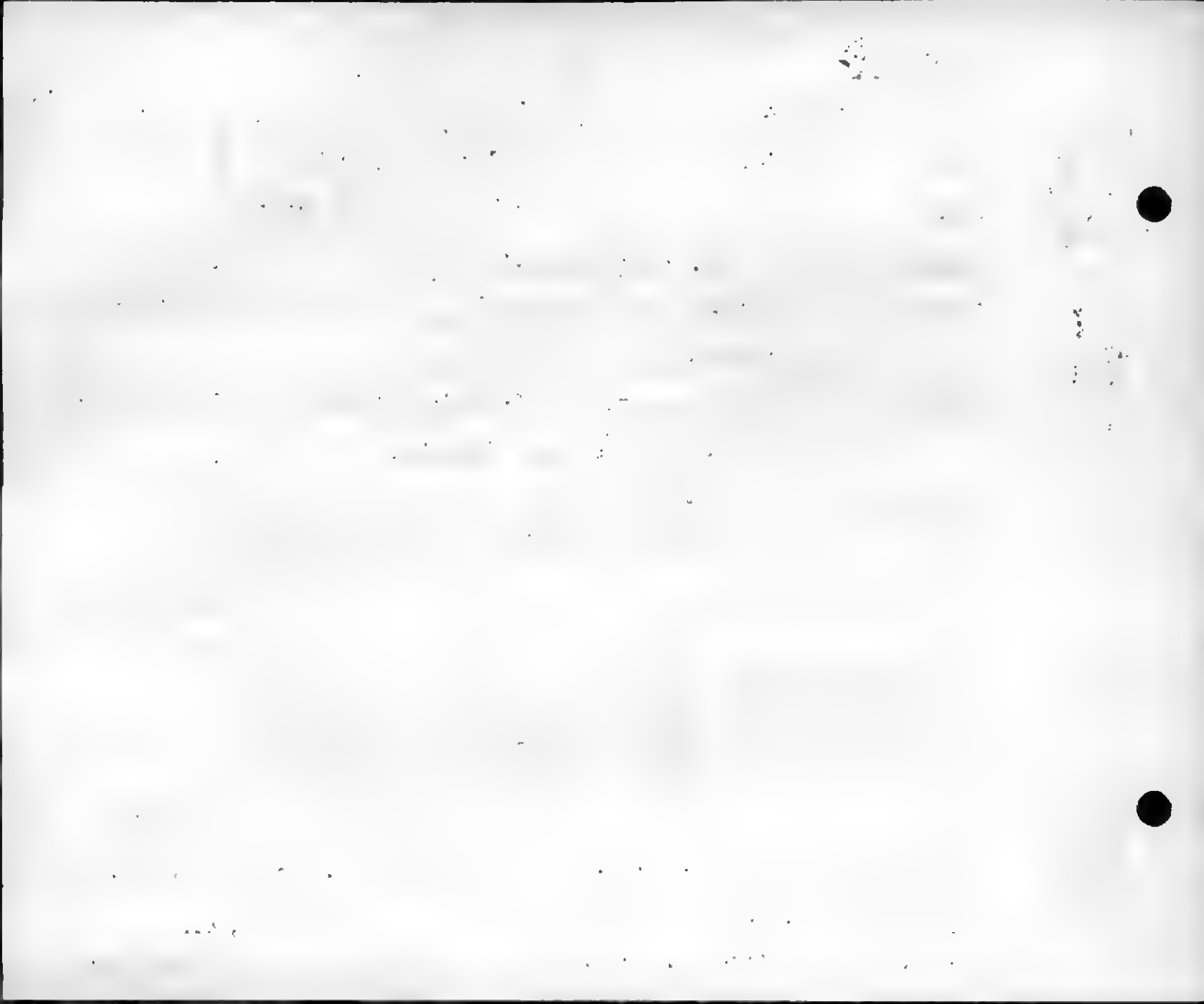
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---------------------|---|-----------------------|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First RAY | Middle CATHERINE | Last FRENCH | 2a. DATE OF DEATH Month Nov. Day 30 Year 1968 | | | 2b. HOUR 4:40p M |
| 3 SEX female | | 4. RACE white | | 5. DATE OF BIRTH 12/5/1889 | | 6 AGE (in years last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS 78 | IF UNDER 24 HRS HOURS 4 MIN 40 |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore | | | Md |
| 10 CITY OR TOWN OF DEATH Middle River | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1228 Wilson Point Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY at home | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Middle River | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1228 Wilson Point Rd. | |
| 14 FATHER'S NAME First William C. Middle Haupt Last | | | | 15 MOTHER'S MAIDEN NAME First Theresa Middle King Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 212-26-2009 | | 17 INFORMANT 719 N. Kenwood Ave. 21205 Dolores T. Feuchter, dght, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid Arthritis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-30 , 1968, to 12-1 , 1968, that (I) (we) last saw the deceased alive on 11-29- 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. John B. Littleton | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 12-2-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. John B. Littleton | | | | 22e. ADDRESS Eastpoint Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>Item 7b Film 406 11/11/68</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15537</div> <div>15540</div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | | | | | |
|--|--|--|--------------------------|--|--------|--|----------|---|--------------------------|--|----------|--|--|
| 1. DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 20. DATE OF DEATH | | 2b. HOUR | | |
| Concetta | | | | | | | GIARDINA | | Month 11 Day 6 Year 1968 | | 12 45 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| Female | | White | | September 7, 189D | | | | 78 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Italy | | USA | | | | Baltimore, Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Towson | | St. Joseph Hospital | | Homemaker | | | | | | | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Baltimore | | Baltimore | | | | 5432 Addington Rd. | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| Giardina | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| no | | | — | | | Mr. Harry Giardina | | | 1119 Providence road | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Possible cerebral infarction | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) Pneumonia | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) Diabetes mellitus | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/3/1968, to 11/6/1968, that (I) (we) last saw the deceased alive on 11/6/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Camilo L. Tombac DEGREE | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Camilo Tombac, M.D. | | | | | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 11/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave. Balto. 21229 | | | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 8 33 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ☒ attending physician.

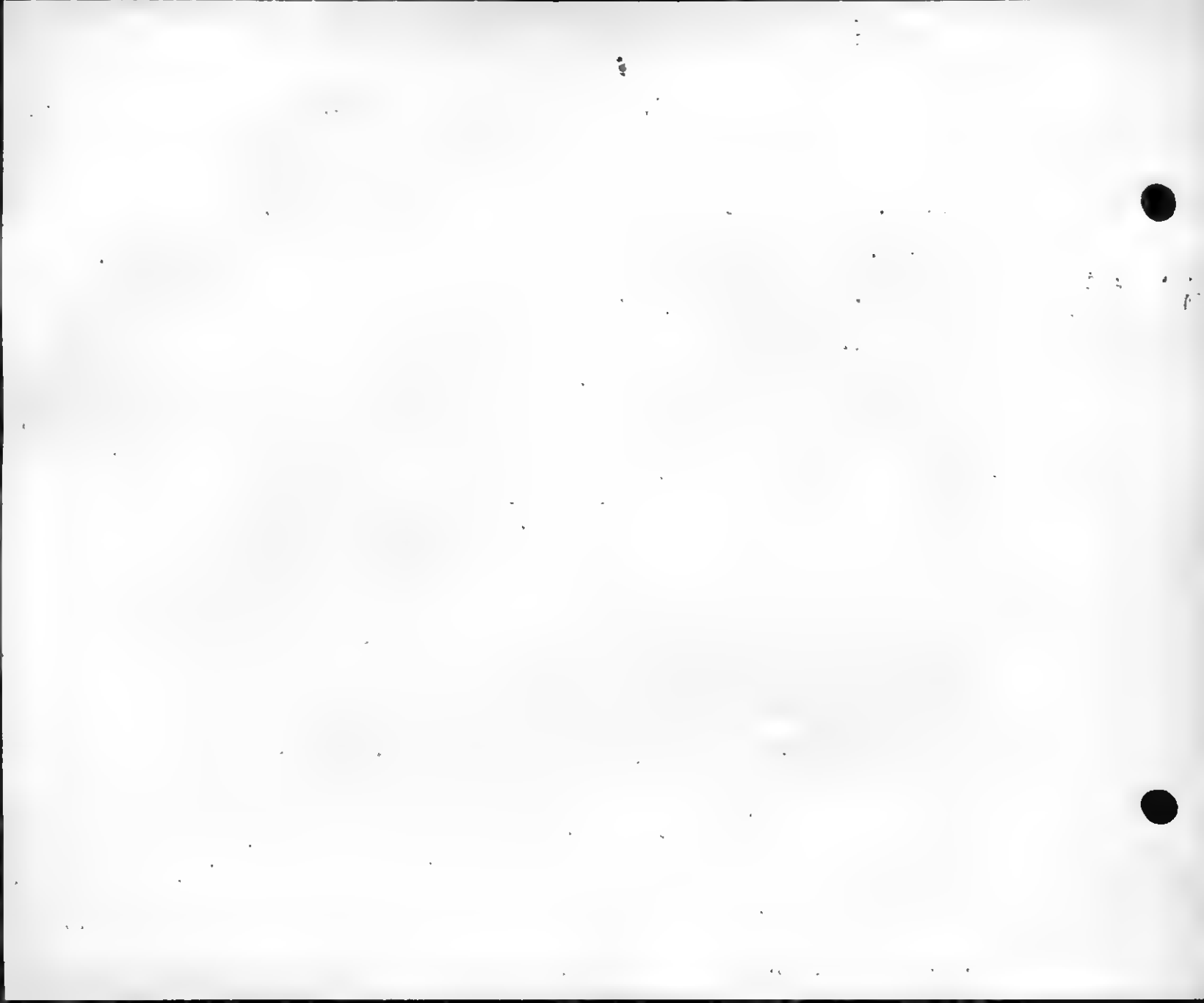
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (Rev. 1-60)
30M REV. 1-60

15538
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

155-0

| | | | | | | |
|---|--|--|--------------------|--|--|---|
| 1 DECEASED NAME (Type or print) <i>Harry</i> | | First <i>E.</i> | Middle <i>Gill</i> | Last | 2c DATE OF DEATH Month <i>Nov.</i> Day <i>21</i> Year <i>68</i> | 2b HOUR <i>10:15 AM</i> |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH <i>August 26, 1886</i> | | 6 AGE (In years lost birthday) <i>82</i> YRS. |
| 7a BIRTHPLACE (State or foreign country) <i>Balto. Co.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> |
| 10 CITY OR TOWN OF DEATH <i>Reisterstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Berrymans Lane</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Maryland State Police Dept.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i> | | 13b COUNTY <i>Balto.</i> | | 13c CITY OR TOWN <i>Reisterstown</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME First <i>Ellsworth</i> Middle <i>Gill</i> Last <i>Parish</i> | | 15 MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Parish</i> Last <i>Parish</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | |
| 16b SOCIAL SECURITY NO. <i>216-30-0258</i> | | 17 INFORMANT Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis - generalized</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Years</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>65</i> , to <i>November 21</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>November 20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE <i>Clarence E. McWilliams M.D.</i> | | | | | | 22c. DATE SIGNED <i>11-22-68</i> |
| 22d. PHYSICIAN'S NAME (Type) <i>11904 Reisterstown Rd Reisterstown Md</i> | | | | | | 22e ADDRESS |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>11/25/68</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Grace Methodist</i> | | 23d LOCATION (City or Town) (County) (State) <i>Falls Rd. Balto. Co. Md.</i> |
| 24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 25 1968</i> | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
304A REV 1/68

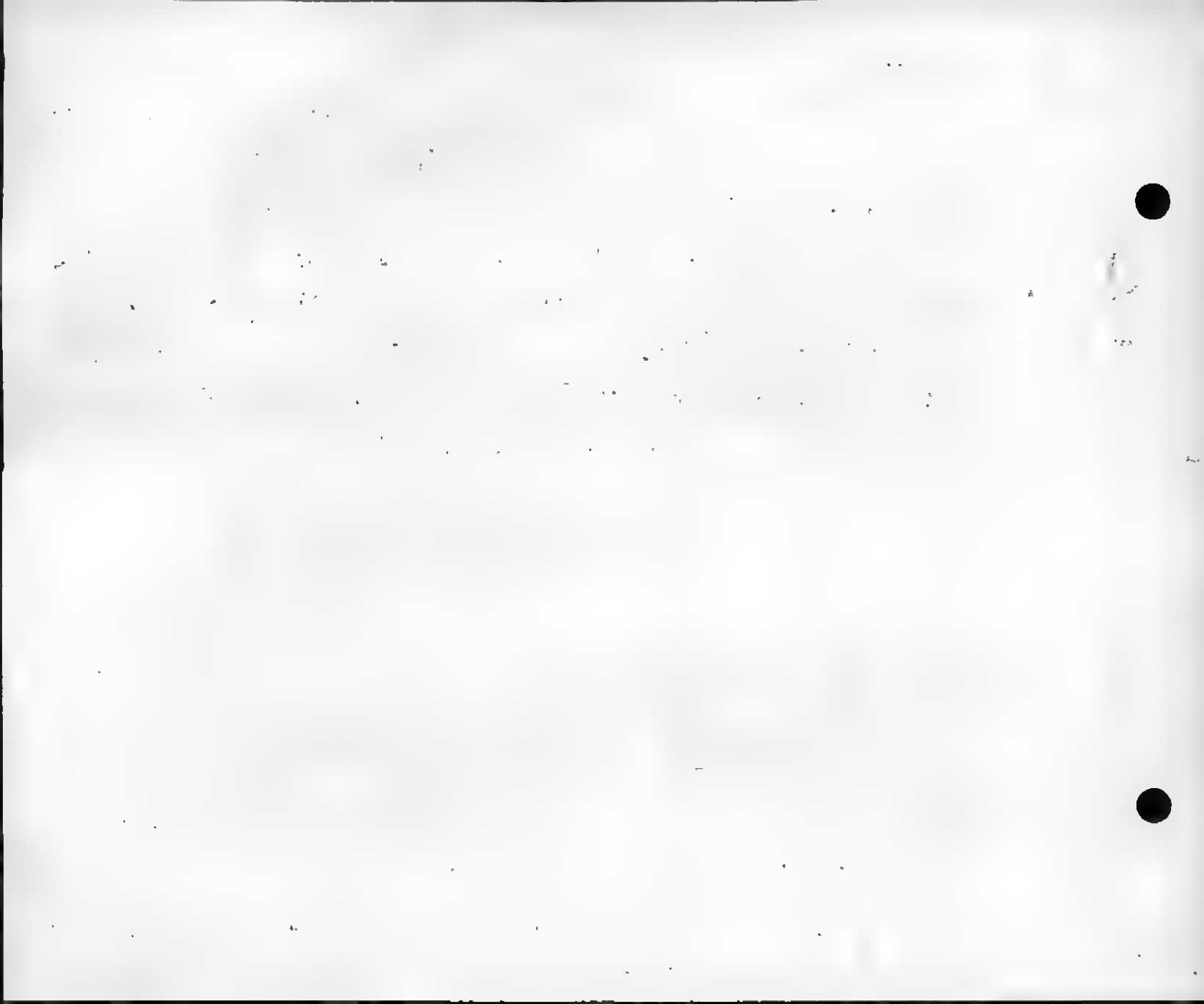
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15539

CERTIFICATE OF DEATH

15551

| | | | | | |
|---|---|---|--|--|---|
| 1 DECEASED NAME (Type or print) First Middle Last HARRY TILDEN GLADDING | | | 2a. DATE OF DEATH Month Day Year November 23 1968 | | 2b. HOUR 10:45 M |
| 3 SEX Male | 4. RACE White | 5. DATE OF BIRTH June 30, 1918 | | 6. AGE (In years last birthday) 50 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Towson | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GAS STATION | 12b. KIND OF BUSINESS OR INDUSTRY OWNER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if instituton. Residence before admission) STATE Maryland | 13b. COUNTY A.A. | 13c. CITY OR TOWN Annapolis | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 710 Americana Dr. | |
| 14 FATHER'S NAME First Middle Last Chinton Ghadding | | 15 MOTHER'S MAIDEN NAME First Middle Last Laura KERNER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES WW II | | 16b. SOCIAL SECURITY NO 216 019125 | 17. INFORMANT MILDEED F. Ghadding #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral carcinoma, metastatic</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>163x</u> (b) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypostatic pneumonia</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
| 22a. I certify that (x) (this hospital) attended the deceased from <u>10-24</u> , 19 <u>68</u> , to <u>11-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Eugenio Antonio</u> | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 11-23-68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Eugenio Antonio | | | 22e. ADDRESS St. Joseph's Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 11-27-68 | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest | 23d. LOCATION (City or Town) (County) (State) Annapolis A.A. MD. | | |
| 24. FUNERAL DIRECTOR John M. Layton & Sons Annapolis, Md. | | | 25a. REC'D BY REGISTRAR DATE NOV 29 1968 | 25b. REGISTRAR'S SIGNATURE f. Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

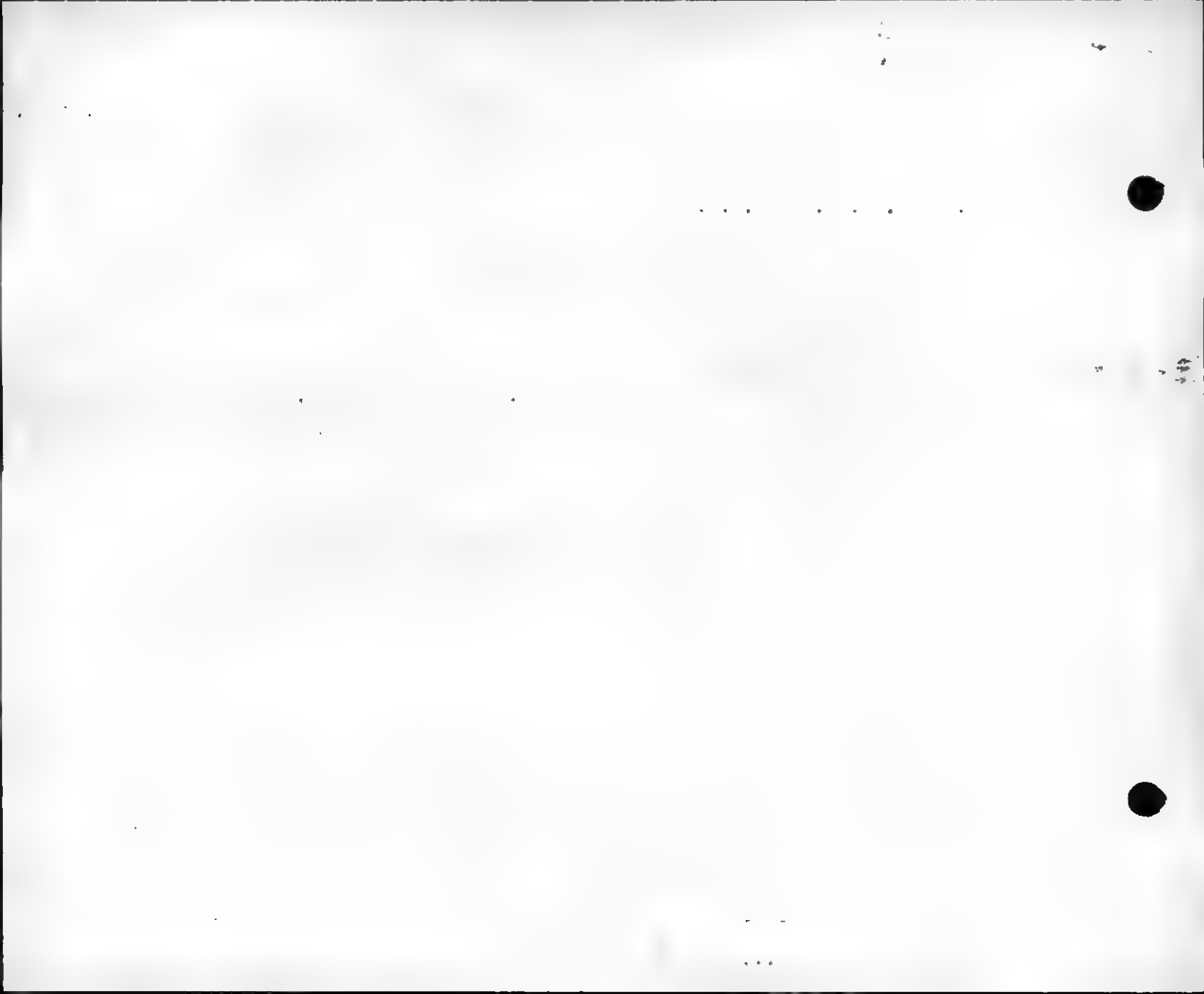
15552

15540

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (Type or print) First Middle Last JULIA ABEL GOLDBERG | | | 2a. DATE OF DEATH Month Day Year NOVEMBER 12, 1968 | | 2b. HOUR 1:40 PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH APRIL 17, 1905 | | 6. AGE (In years last birthday) 63 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) MT. HOPE, W. VA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHAPEL HILL NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND | | 13b. CITY OR TOWN BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 13d. STREET AND NUMBER 6620 VINCENT LANE | | 14. FATHER'S NAME First Middle Last SAMUEL ABEL | | 15. MOTHER'S MAIDEN NAME First Middle Last LYDIA ? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address MR. ISIDORE GOLDBERG, 6818 NAVAJO DRIVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary with metastases 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MOS. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1750 none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 18, 1966 , to Nov. 13, 1968 , that (I) (we) last saw the deceased alive on Nov. 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Marvin Goldstein, M.D. | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/14/68 | |
| 22d. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN | | 22e. ADDRESS 6001 PARK HEIGHTS AVENUE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON) | |
| 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 11 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

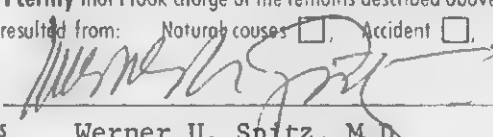
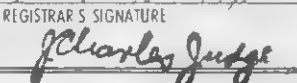
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15542

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15553

Item #23c, Per telephone MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|-----------------------------|--|--|--|--|
| 1 DECEASED NAME (Type or Print) First Middle Last GRACE XXXX GOLDSTEIN | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 68 | | 2b HOUR M 9:30 |
| 3 SEX female | 4 RACE white | 5 DATE OF BIRTH 3-12-92 | 6 AGE (In years last birthday) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 76 | 7 UNDER 24 HRS HOURS MIN 76 |
| 7a BIRTHPLACE (State or foreign country) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH Arbutus | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 932 Regina Drive | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secretary |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) - STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN Arbutus | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER 932 Regina Drive |
| 14 FATHER'S NAME First Middle Last Unknown | | | 15 MOTHER'S MAIDEN NAME First Middle Last Unknown | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO (If yes give war or dates of service) | | 17 INFORMANT Reistens ADDRESS, Md. 21136 Mrs Helen M. Yager 32 Greenville Ave. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Poisoning DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a DATE OF OPERATION 11-29-68 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? sub. ingested an overdose of barbiturates | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH UNK M. UNK 19 | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. UNK 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) sub. ingested an overdose of barbiturates | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home | | 21f LOCATION Street or R.F.D. No City or Town County State Baltimore, Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MED. CAL. EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b DATE SIGNED 11/26/68 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE 11-29-68 | 23c NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | 23d LOCATION (City or Town) (County) (State) A.A. Co. Md. Arbutus | | |
| 24 FUNERAL DIRECTOR F.H. 237 Latrobe Ave. Baltimore | | ADDRESS 3122 S | | 25a REC'D BY REGISTRAR NOV 29 1968 | 25b REGISTRAR'S SIGNATURE  |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

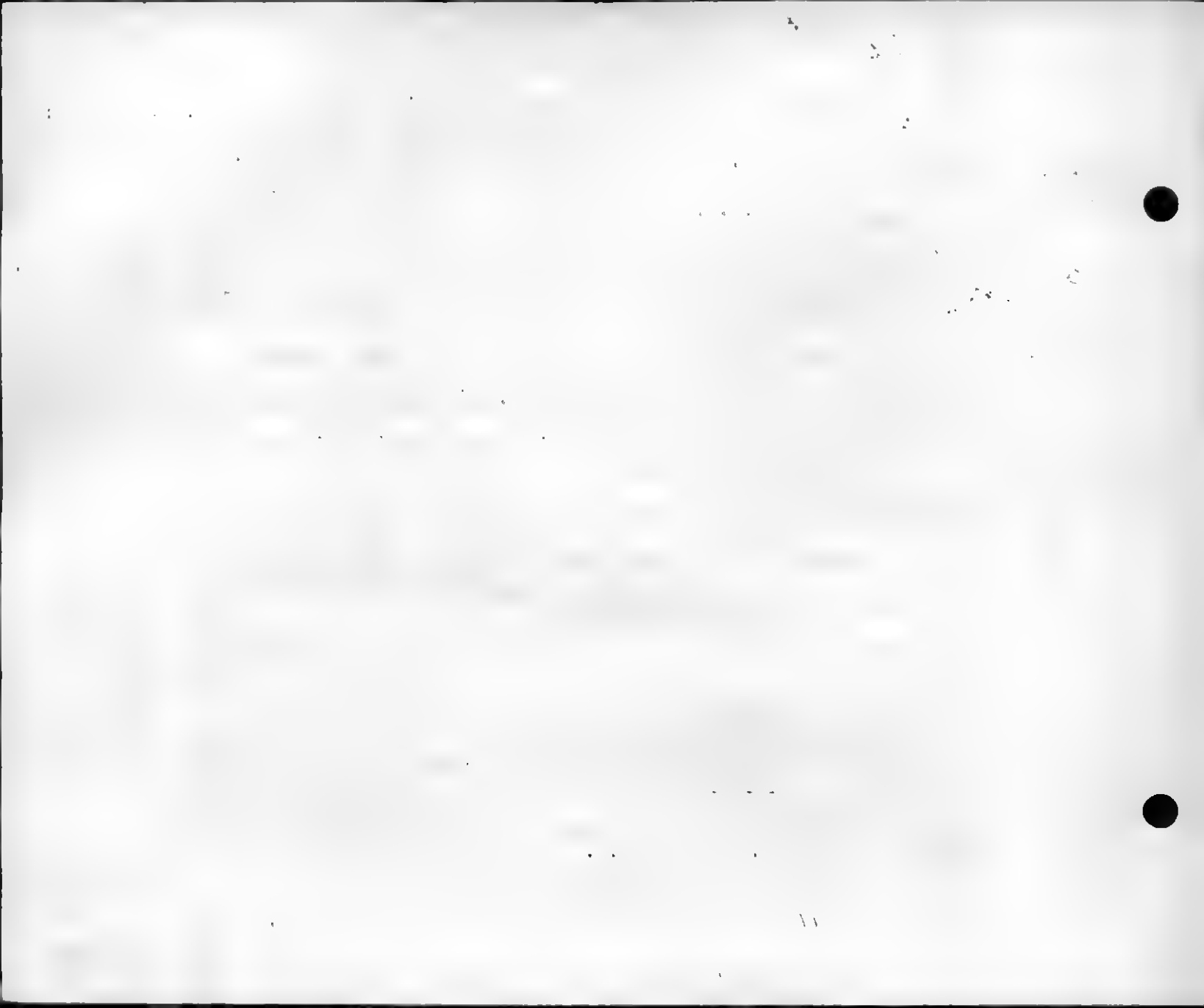
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15548

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1355

| | | | | | | | | | | |
|---|---|---|--|--|--|---|--------|---|------|-------------------|
| 1. DECEASED NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF EST. DEATH MATED | | Month | Day | Year | 2b. HOUR |
| RAYMOND | | | ALOYDIA | Alawishis | GONCE | <input type="checkbox"/> Nov. 15, 1968 | | | | 1:55 ^P |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS HOURS | | 2c. DATE PRONOUNCED DEAD Month | | 2d. HOUR |
| Male | White | Mar. 28. 1898 | 70 YRS | | | | | Nov. 15, 1968 | | 1:55 ^A |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Balto. Md. | U.S.A. | | | Baltimore | | Cushman Trans. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Parkville | 2621 Proctor Lane-Rear yard | | Chauffeur | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INS. DE CITY LIMITS? | 13e. STREET AND NUMBER | | 13f. STREET AND NUMBER | | | | |
| Maryland | Baltimore | Balto. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 9904 Madgett Road | | Co. | | | | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| William Gonce | | | | Elizabeth Clautice | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO | 17. INFORMANT | | ADDRESS | | | | | | |
| No | 212-09-4178 | Mrs. Mildred Chester | | -9904 Madgett Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4-1 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or RFD No City or Town County State | | | | | | |
| | | | | (Partial) | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | Ronald N. Kornblum, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | November 15, 1968 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | |
| | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 11-18-68 | | Holy Redeemer Cemetery | | Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | DATE NOV 19 1968 | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|---|---|--------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15542 CERTIFICATE OF DEATH 15555 | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First MIDDLE Last ABRAHAM CHARLES A GORDON | | | 2a DATE OF DEATH Month 11 Day 13 Year 68 | | | 2b HOUR 4:37 PM |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH 12-18-97 | | 6 AGE (In years last birthday) 70 YRS. | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) BALTO., MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore County Md | | | |
| 10 CITY OR TOWN OF DEATH Randallstown | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY LITZ CO. | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b COUNTY Balto. | | 13c CITY OR TOWN Balto. | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 11 Slade Ave., APT. 315 | |
| 14. FATHER'S NAME First MIDDLE Last ABRAHAM GORDON | | | 15. MOTHER'S MAIDEN NAME First MIDDLE Last MOLLIE ? | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address MRS. IRENE GORDON, 11 SLADE AVE., APT. 315 #8 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE CORONARY ARTERY DISEASE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 6 months 2 years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or RFD No. | | City or Town | | County State | |
| 22a I certify that (I) (this hospital) attended the deceased from 10-5-1966, to 11-13-1968, that (I) (we) last saw the deceased alive on 11-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cesar Valle Caveno | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-13-68 | |
| 22d PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO | | | | 22e ADDRESS 8624 Liberty Rd. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 11-14-68 | | 23c NAME OF CEMETERY OR CREMATORY (ANSHE EMUNAH) AITZ CHAIM | | 23d LOCATION (City or Town) BALTIMORE, MARYLAND | | (County) (State) | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | ADDRESS NOV 18 1968 | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>15544</div> <div>15556</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | |
|--|--|--|---|--|--------------|---|------------------------|--|--|--------|--|--|--|
| 1 DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| ROBERT | | | MILTON | | GORMLEY, SR. | | Month 11 Day 5 Year 68 | | | 9:40PM | | | |
| 3. SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | 7 IF UNDER 1 YEAR | |
| MALE | | | WHITE | | | 5/26/11 | | | 57 YRS | | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | |
| FORT HOWARD, MD. | | | U.S.A. | | | | | | BALTIMORE COUNTY, | | | Md | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a U.S.A. OCCUPATION (Kind of work done during normal working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| FORT HOWARD | | | VET. ADM. HOSPITAL | | | FURNITURE FINISHER | | | FURNITURE CO. | | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e STREET AND NUMBER | |
| MARYLAND | | | | | | BALTIMORE | | | | | | 5500 GERLAND AVENUE | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| MILTON A. GORMLEY | | | CLAUDIA DeVeny DEWINE | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | Address | | | | |
| YES | | | WW II | | | 220 01 51 13 | | | CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA | | | | | | | | | | | | RECENT | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | OLD | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 10/30/68, 19, 11/5/68, 19, that (X) (we) last saw the deceased alive on 11/5/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE | | | ERHARD J. BUNYOR | | | DEGREE | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 11/6/68 | |
| 22d PHYSICIAN'S NAME (Type) | | | ERHARD J. BUNYOR, M. D. | | | 22e ADDRESS | | | VAH FORT HOWARD, MARYLAND | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Type) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | 11-9-68 | | | DULANEY VALLEY CEMETERY | | | BALTIMORE, MARYLAND | | | | |
| 24 FUNERAL DIRECTOR | | | RUCK FUNERAL HOME | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | | | |
| | | | 5305 H. rford Rd. Baltol. Md. | | | NOV 7 1968 | | | Charles Judge | | | | |

15545

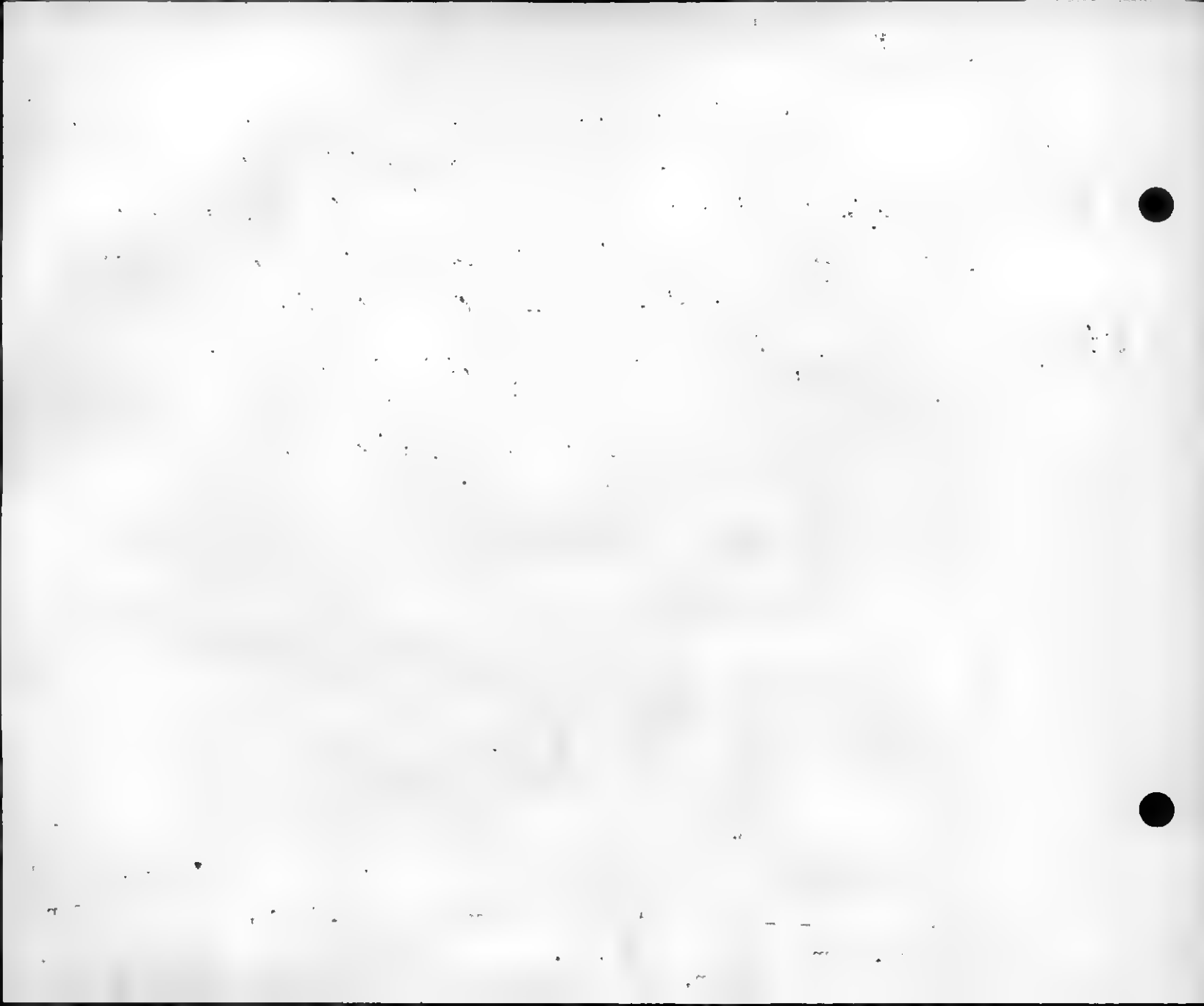
CERTIFICATE OF DEATH

1555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Se. Mary Henrica Grabska</i> | | | 2a. DATE OF DEATH Month <i>11</i> Day <i>9</i> Year <i>68</i> | | | 2b. HOUR <i>5:30 PM</i> | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5 DATE OF BIRTH <i>1-4-1917</i> | | 6. AGE (In years last birthday) <i>51</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH <i>Baltimore</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Glen Arm</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Villa Maria</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Teacher</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Glen Arm</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Joseph</i> Middle <i>Grabska</i> Last <i>Grabska</i> | | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Linski</i> Last <i>Linski</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | |
| 17 INFORMANT <i>Se. M. Kathleen</i> | | Address <i>same</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Positive Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1974</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 10</i> , 19 <i>68</i> , to <i>11-7</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>11-7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Henry L. McCorkle MD</i> | | DEGREE <i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) <i>HENRY L. MCCORKLE MD</i> | | 22e. ADDRESS <i>Phoenix Md (21131)</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11-12-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Sisters Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR <i>Raymond J. Cutran</i> | | ADDRESS <i>817 Scarlett Dr. Towson, Maryland 21204</i> | | 25a. REC'D BY REGISTRAR <i>NOV 14 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

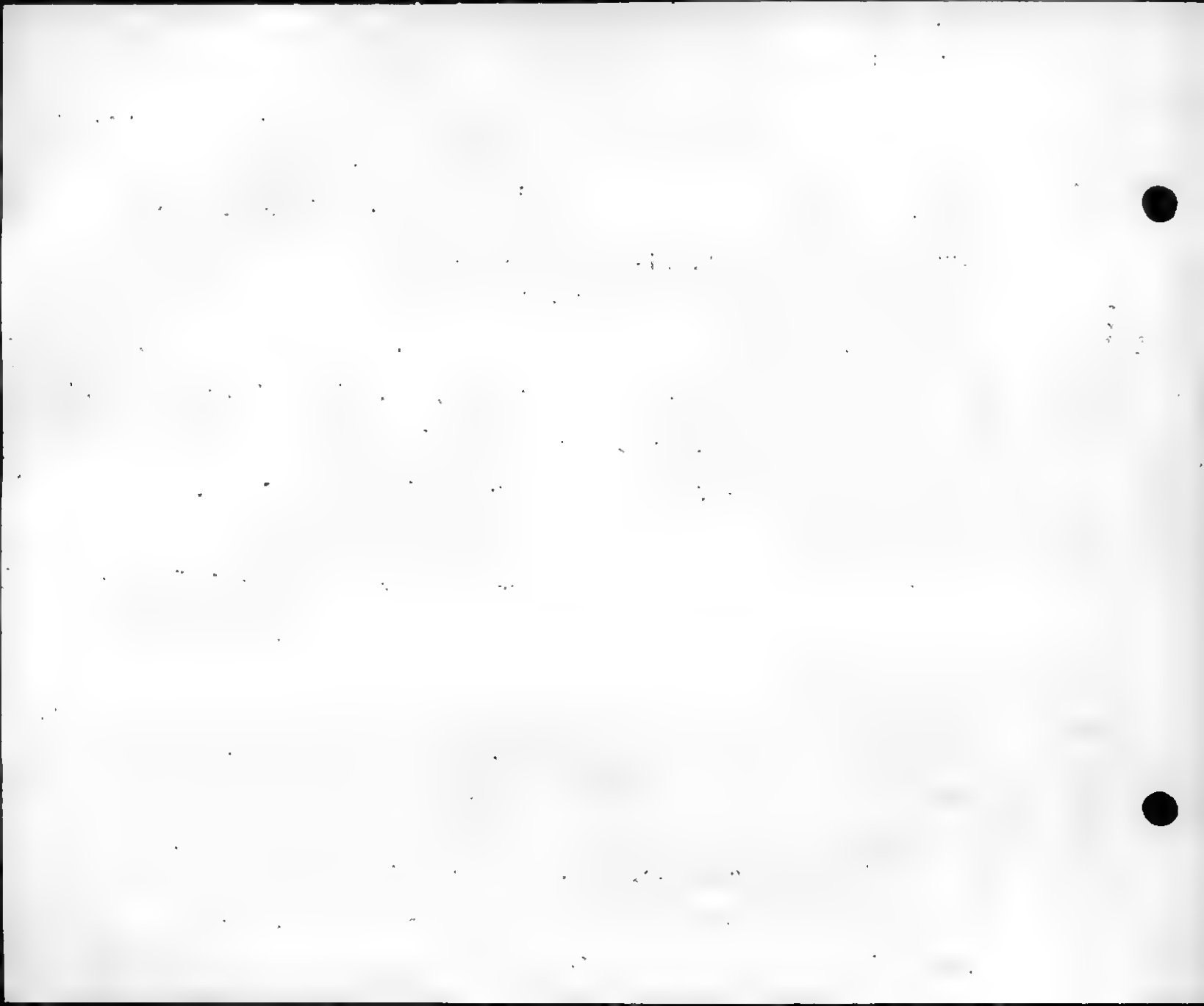


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

| 15548 | | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|------------------|-----------------------------------|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| FRANK | | | GREEN | | | Month 11 Day 21 Year 1968 | | | 7:45 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Negro | | 5/15/1902 | | | 68 YRS. | | MONTHS DAYS HOURS | | M.N. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Virginia | | U. S. A. | | | | Baltimore County, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Mount Wilson | | | Mt. Wilson State Hosp. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | | Baltimore | | Baltimore | | | | 220 North Curran St. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Charles | | | Green | | | Mary (?) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | |
| | | | 213-05-8965 | | | Records, Mt. Wilson State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>780X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>497X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CARCINOMA OF PANCREAS & SCATTERED METASTASES</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/28/1968</u> to <u>11/21/1968</u> , that (I) (we) last saw the deceased alive on <u>11/21/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>W. Newcomer</u> | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u> | | | | | | 22e. ADDRESS <u>Mount Wilson, Maryland</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 11-25-68 | | Arbutus Mem. Park | | Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| WM. MARCH 928 E. North Ave | | | | DATE NOV 25 1968 | | <u>J. Charles Judge</u> | | | | | | |



FOR STATE
HEALTH DEPT.

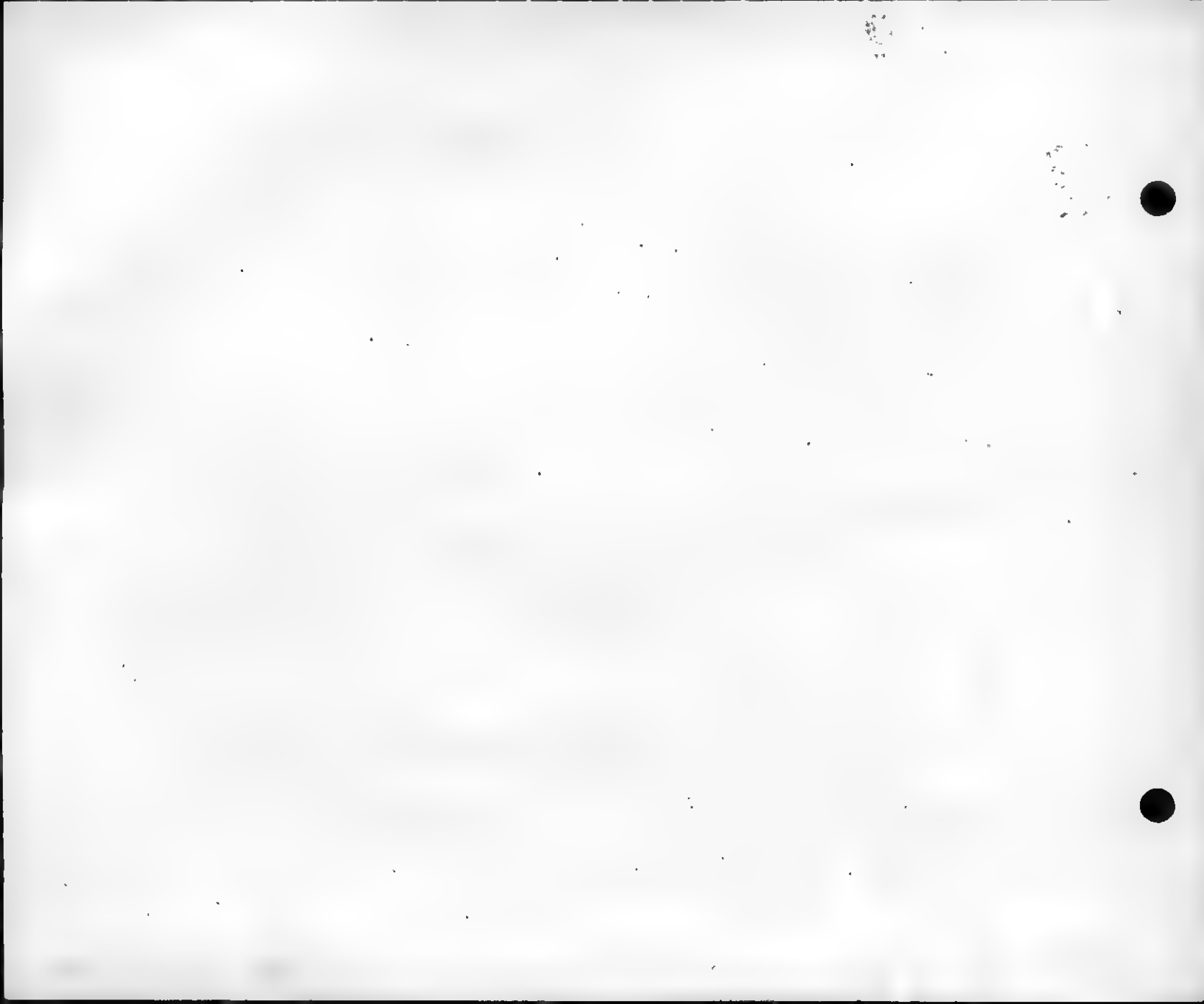
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15547

| | | | | | |
|---|------------------------|---|--|--|--|
| 1 DECEASED NAME (Type or Print) First Middle Last Anthony Joseph Guido | | | 2a DATE KNOWN OF DEATH EST. MATED Month Day Year 11 18 1968 | | 2b HOUR M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH 11/2/16 | 6 AGE (in years last birthday) 52 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign) Balto., Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9 COUNTY OF DEATH Baltimore | | | 12c DATE PRONOUNCED DEAD Month Day Year 11 18 1968 | | 2d HOUR M |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give local address) 7709 Eastdale Road | | 2a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steelworker | |
| 12b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | | 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland | | 13b COUNTY Baltimore | |
| 13c CITY OR TOWN Balto. | | 3d INSIDE CITY-YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 7709 Eastdale Road | |
| 14 FATHER'S NAME First Middle Last Pasquale Guido | | | 15. MOTHER'S MAIDEN NAME First Middle Last Josephine Petrilli | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16b SOCIAL SECURITY NO W.W.11 213-07-0227 | | 17. INFORMANT ADDRESS Mrs. Pearl Guido Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCVD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2, Item 18) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Theo C. Patterson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 11/20/68 | |
| EXAMINER'S NAME (Type) THEO C. PATTERSON | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ADDRESS (Street, city, town, or county) 263 S. Conkling Street | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/21/68 | | 23c NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | |
| 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | 23e REC'D BY REGISTRAR NOV 25 1968 | | 23f REGISTRAR'S SIGNATURE Charles Judge | |
| 24 FUNERAL DIRECTOR Joseph M. Zannino | | ADDRESS 263 S. Conkling Street | | | |

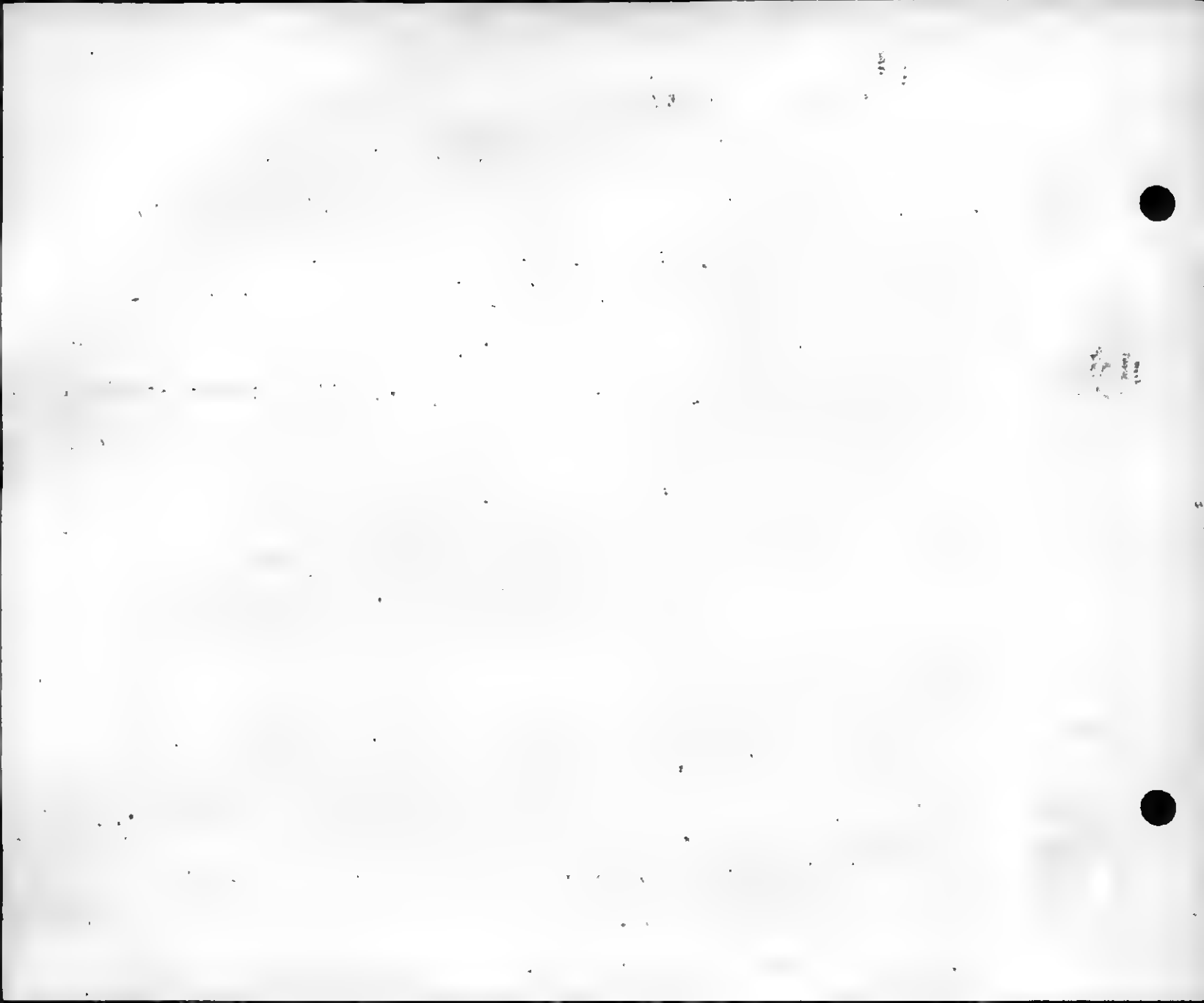


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VR A15 (4)
30M REV. 1/68

| 15548 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 15560 | |
|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) | | | 2a. DATE OF DEATH | | |
| First MARY ANTONETTE GUNNING | | | Month 11 Day 13 Year 68 | | |
| 3. SEX F | | | 4. RACE W | | |
| 5. DATE OF BIRTH 11/13/1901 | | | 6. AGE (In years last birthday) 67 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) Carversburg W. Va. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore County, Md | | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp. | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | 13b. CITY OR TOWN 8 Decatur Str. | | |
| 13c. COUNTY Allegany | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First WILLIAM Middle FRICKER Last | | | 15. MOTHER'S MAIDEN NAME First EMMA Middle C. Last HUCH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | 16b. SOCIAL SECURITY NO 220-16-2531 | | |
| 17. INFORMANT Address Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia | | | | | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emphysema, severe | | | | | 5 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| I. Cor Pulmonale II Intestinal Obstruction | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11.7, 1968, to 11.13, 1968, that (I) (we) lost saw the deceased alive on 11.13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William Newcomer | | | | 22c. DATE SIGNED 11/13/1968 | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | 22e. ADDRESS Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery Cumberland Allegany Maryland | |
| 23d. LOCATION (City or Town) (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR H. Lee Silcox | | ADDRESS Cumberland Maryland 21502 | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

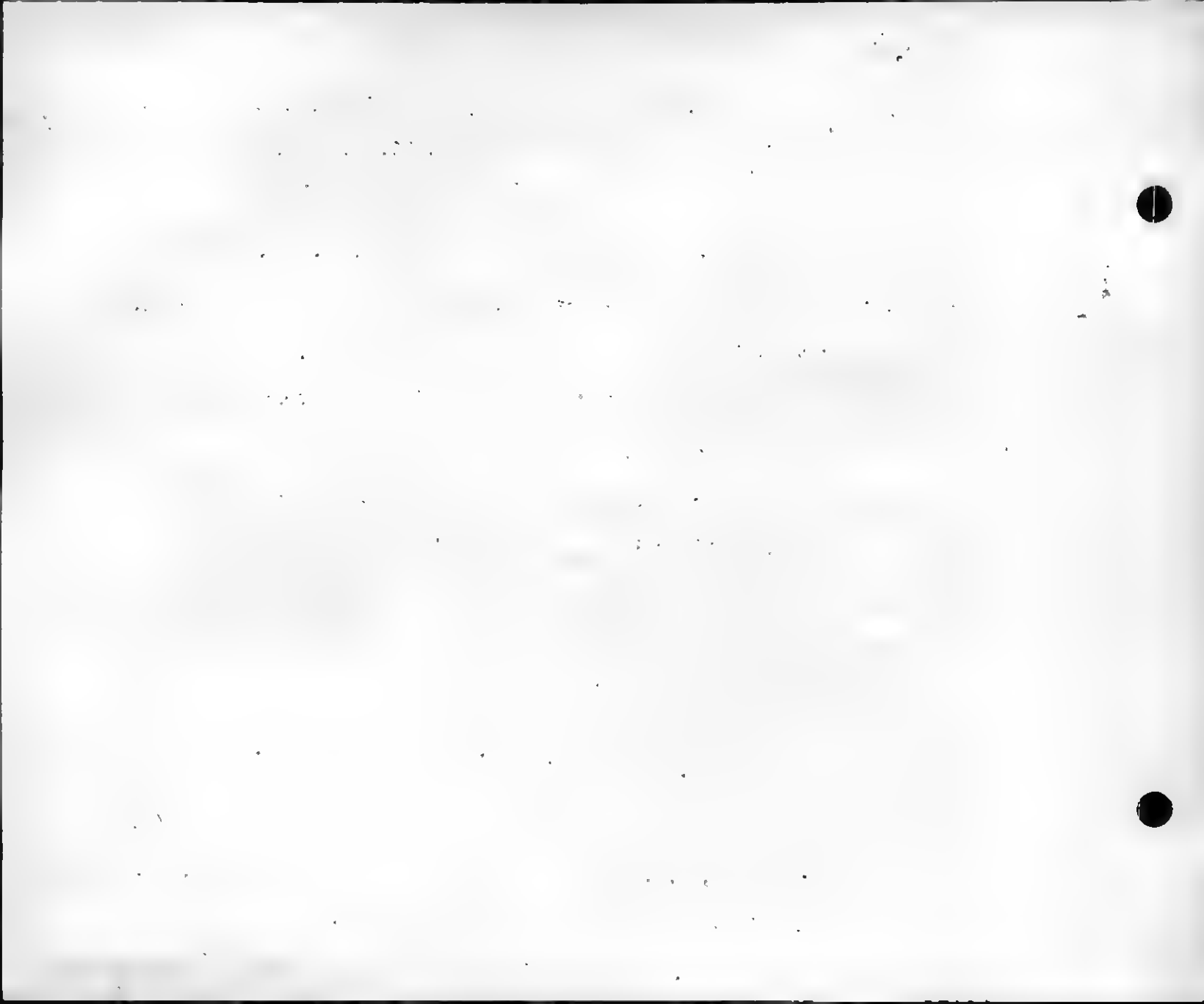


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VR A15 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 15549 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15561 </div> | | | | | | | | | | | |
|---|--|--|---|--|--|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| RACHEL | | | EMALIY | | | HALE | | | November 10 1968 6:30 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years and birthday) | | 7. IF UNDER 1 YEAR | | |
| Female | | White | | Dec. 20, 1883 | | | 84 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | |
| Baltimore | | USA | | | | | Baltimore | | | Md. | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| St Joseph's Hospital | | | Homemaker | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | — | | | Baltimore | | | 525 Tunbridge Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John M. Hammond | | | Sophia Merryman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 216-10-8595 | | | Wm. Nicoll Hale (Husband) | | | Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>secondary to Arteriosclerotic Cardiovascular</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Disease: Pernicious Anemia</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 45 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18</u> , 19 <u>69</u> , to <u>Nov. 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| Camilo L. Tomboc | | | | | | | | 11/10/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | |
| Camilo Tomboc, M.D. | | | | | | | | 7620 York Road Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | Nov. 12, 1968 | | Druid Ridge Cemetery | | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Eutenia K. Seitz 5200 York Rd. Balto. Md. | | | | | | DATE NOV 12 1968 | | J. Charles Judge | | | |
| Seitz Funeral Home 21212 | | | | | | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

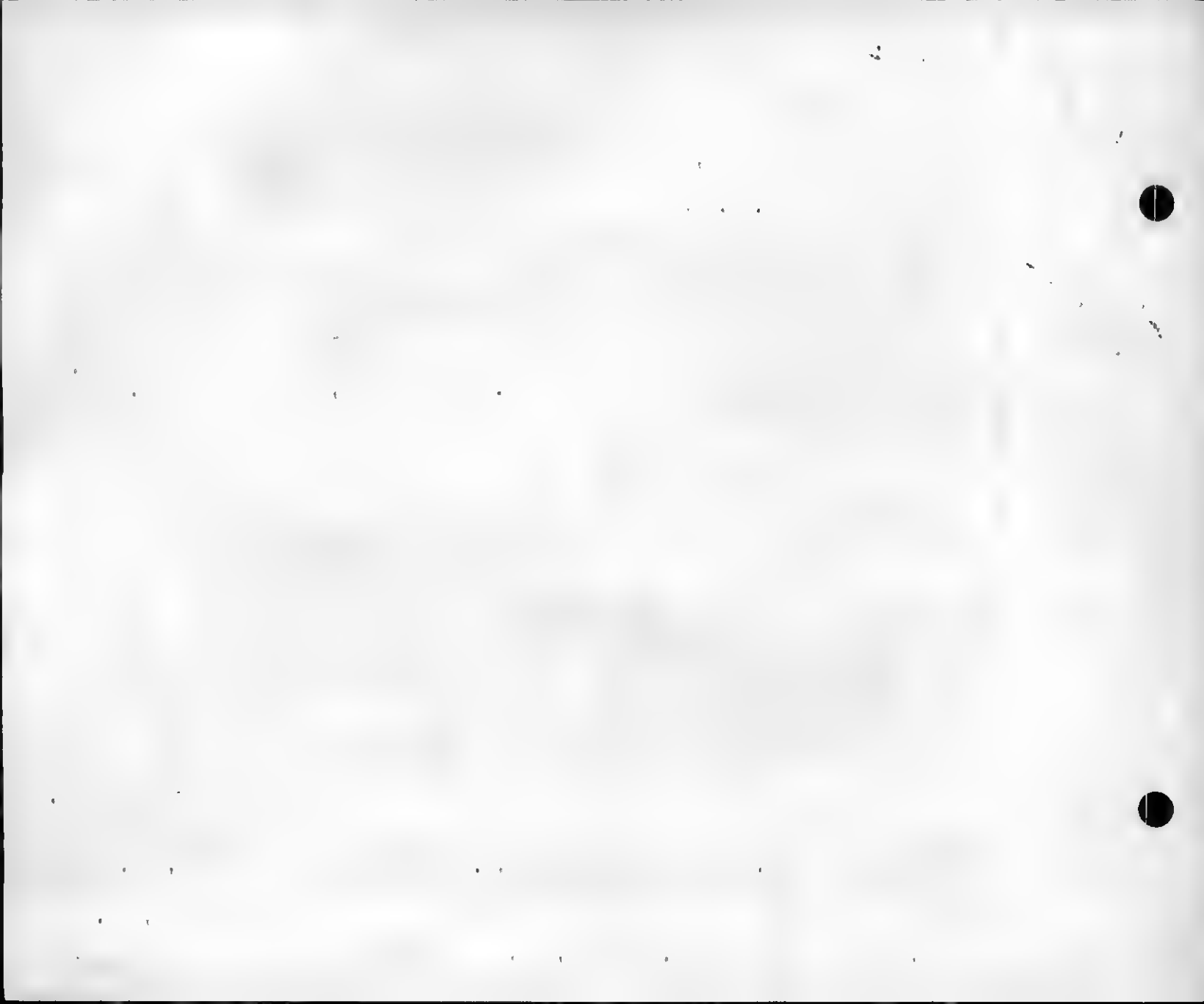
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

15550

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15550

| | | | | | | | | |
|--|-------------------------|--|--|---|---|---|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last Katherine Hamilton | | | 2a. DATE KNOWN OF DEATH Month Day Year 11-30-68 | | | 2b. HOUR 10 P.M. | | |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH Jan. 19, 1877 | 6. AGE (In years last birthday) 91 YRS. | 7. UNDER 1 YEAR MONTHS DAYS | 8. UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year November 30 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | |
| 10. CITY OR TOWN OF DEATH Dundalk | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2828 Creston Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 2828 Creston Road | | |
| 14. FATHER'S NAME First Middle Last Jeremiah Sullivan | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sally Whalen | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | |
| 16b. SOCIAL SECURITY NO None | | | 17. INFORMANT (Granddaughter) Mrs. Ethel Jordan, 2828 Creston Rd. | | | ADDRESS Dundalk, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V- Disease 4107 DUE TO, OR AS A CONSEQUENCE OF (b) Senility DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED 12/2/68 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Melvin B. Davis M.D. ADDRESS (Street, city, town, or county) Dundalk, Md. 21222 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | 25a. REC'D BY REGISTRAR DEC 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO: Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 15552 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 15563 | |
|---|--|-----------------|--|--|--|---|--|---|--|--|--|-------|--|
| 1 DECEASED NAME (Type or Print) <i>LILY W. HAMILTON</i> | | | | | | 2a DATE KNOWN OF DEATH <i>11 9 1968</i> | | 2b HOUR <i>A. M.</i> | | | | | |
| 3 SEX <i>7</i> | | 4 RACE <i>W</i> | | 5 DATE OF BIRTH <i>9/15/13</i> | | 6 AGE (In years last birthday) <i>65</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a BIRTHPLACE (State or foreign country) <i>SCOTLAND</i> | | | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH <i>BALTO.</i> | | | |
| 10 CITY OR TOWN OF DEATH <i>CATONSVILLE</i> | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <i>205 INGLETSIDE AVE</i> | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>ELECTRIC</i> | | 12b KIND OF BUSINESS OR INDUSTRY <i>RET.</i> | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if not tuition: Residence before admision) STATE <i>MD</i> | | | | 13b COUNTY <i>BALTO CATONSVILLE</i> | | | | 13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET AND NUMBER <i>205 INGLETSIDE</i> | | | |
| 14 FATHER'S NAME First Middle Last <i>ALEXANDER WEBSTER</i> | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last <i>ELIZABETH MCINTYRE</i> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO. <i>215 32 9555</i> | | | | 17 INFORMANT ADDRESS <i>JAMES H. HALE - SON</i> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4 10 Pulmonary Edema</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Congestive Heart Failure</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4 20 Pulmonary Emphysema - Asthma</i> | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i> | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>J. Nelson McKay</i> | | | | CHIEF MED. CAL. EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <i>11/11/68</i> | | | | | |
| EXAMINER'S NAME (Type) <i>J. NELSON MCKAY, MD.</i> | | | | ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | 23b DATE <i>11/13/68</i> | | | | 23c NAME OF CEMETERY OR CREMATORY <i>WOODLAWN</i> | | | | | |
| 23d LOCATION (City or Town) <i>BALTO</i> | | | | (County) <i>MD.</i> | | | | (State) | | | | | |
| 24. FUNERAL DIRECTOR <i>MALINAE + SON</i> | | | | ADDRESS <i>301 FREDERICK RD 21228</i> | | | | 25a REC'D BY REGISTRAR <i>NOV 14 1968</i> | | | | | |
| | | | | | | | | 25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | | | |

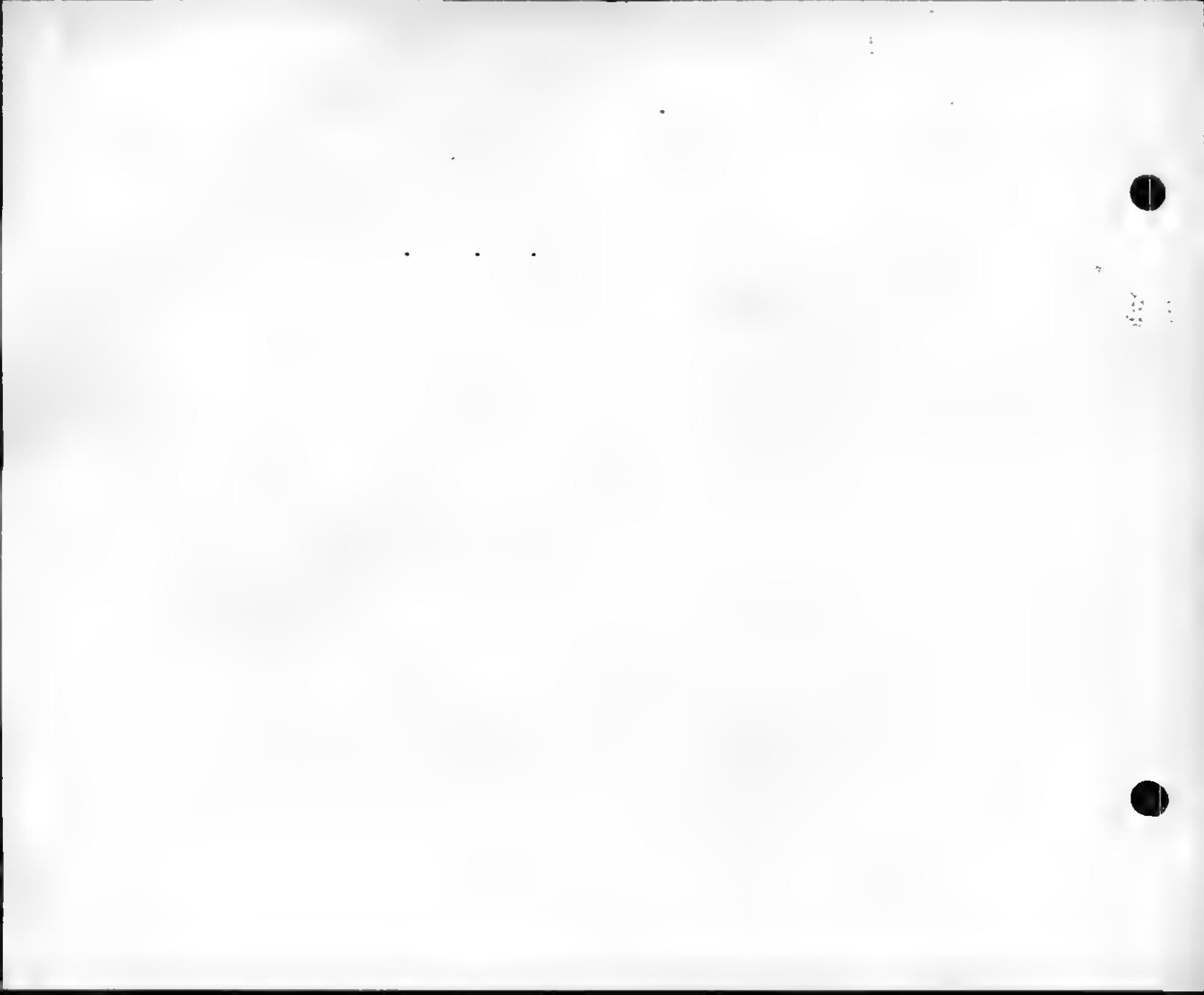


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 155M
30M REV 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15552 Items 7a,b,&8, 13a,c,e Film GL 07 12 / CERTIFICATE OF DEATH 15564 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last George W. Harp | | | | | 2a. DATE OF DEATH 11 Month 30 Day 68 Year | | | 2b. HOUR 2:50am | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH 8-13-1904 | | 6. AGE (In years last birthday) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cent. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3431 Falls Road | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 42% DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7341 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-27 , 19 68 , to 11-30 , 19 68 , that (I) (we) last saw the deceased alive on 11-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE F. Naeim | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-30-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Faramarz Naeim | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec 3, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Vernon Park | | 23d. LOCATION (City or Town) (County) (State) Taylor Ave | | | |
| 24. FUNERAL DIRECTOR Paul E. Chennoweth | | | | ADDRESS 3615 Chestnut Ave | | 25a. REC'D BY REGISTRAR DATE DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



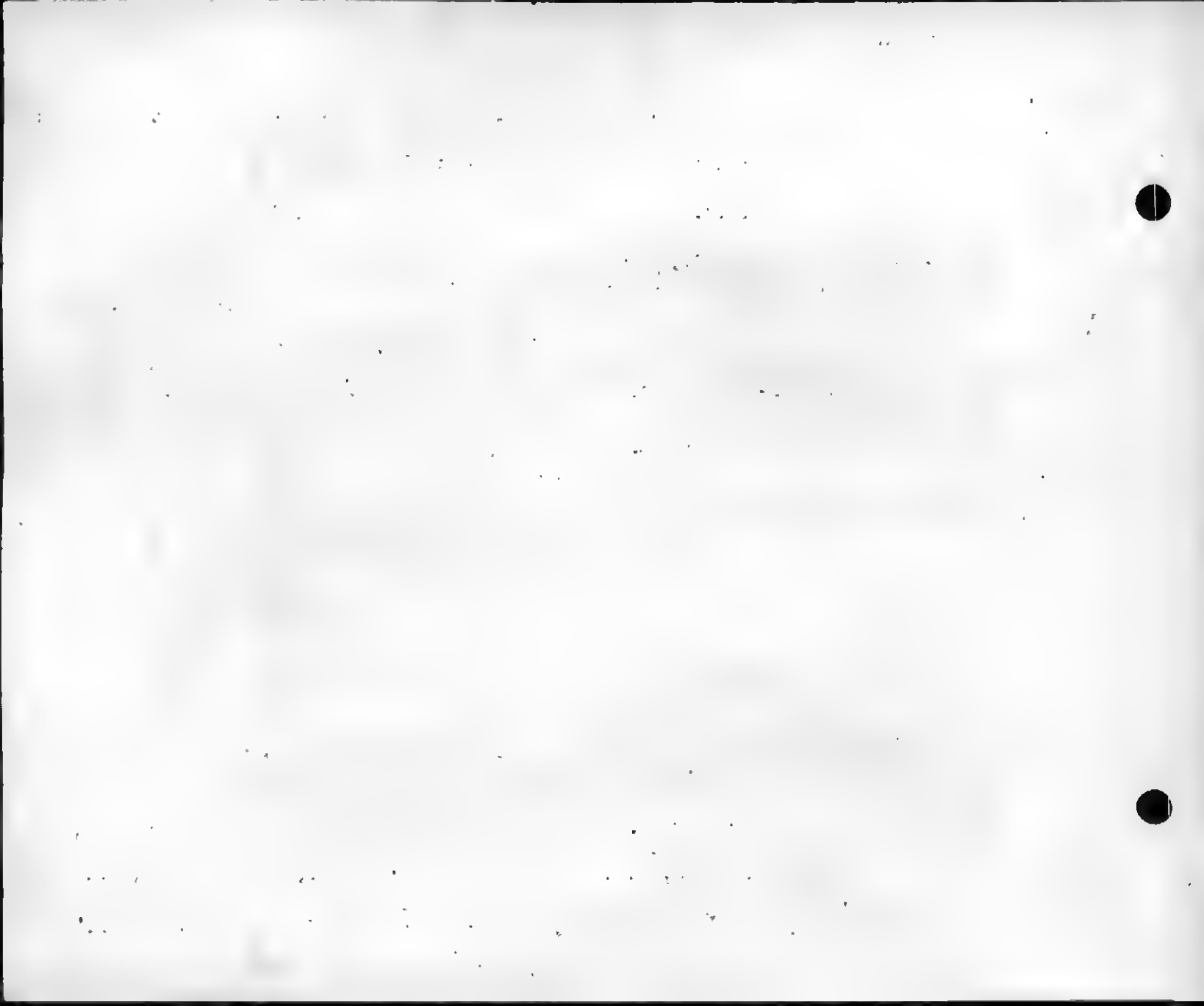
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Page 4 may be retained by the hospital or attending physician

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VR A15 (4)
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--------------------------|---|--------|---|---------------------------------|---|--------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| ANN | | | MARIE | | HARTKA | | November 6, 1968 | | 2b. HOUR PM 10:10 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | White | | October 14, 1965 | | | 8 YRS. | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore | | Md. | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET AND NUMBER | | 13c. STREET AND NUMBER | |
| St. Joseph Hospital | | (Child) | | | | | | 7611 Wilhelm Ave. 21237 | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 13f. STREET AND NUMBER | |
| Maryland | | | | Baltimore | | | | 7611 Wilhelm Ave. 21237 | | | |
| 14 FATHER'S NAME | | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | |
| William T. Hartka | | | | | | | | | REGINA WRZESINSKI | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | Address | | |
| No | | | — | | | WILLIAM T. HARTKA | | | 7611 WILHELM AVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracranial Hemorrhage | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Leukemia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 10, 1968, to Nov. 6, 1968, that (I) (we) last saw the deceased alive on Nov. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jose S. Aguto | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED November 6, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Jose S. Aguto, M.D. | | | | | | | | 22e. ADDRESS 7620 York Rd., Towson 21204, Md. | | | |
| 23a. BURIAL CREMAT. OR REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 11/9/68 | | GARDEN OF FAITHS | | | | BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| RAYMOND L. KACZOROWSKI 2525 FLEET | | | | | | | | DATE NOV. 18 1968 | | Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

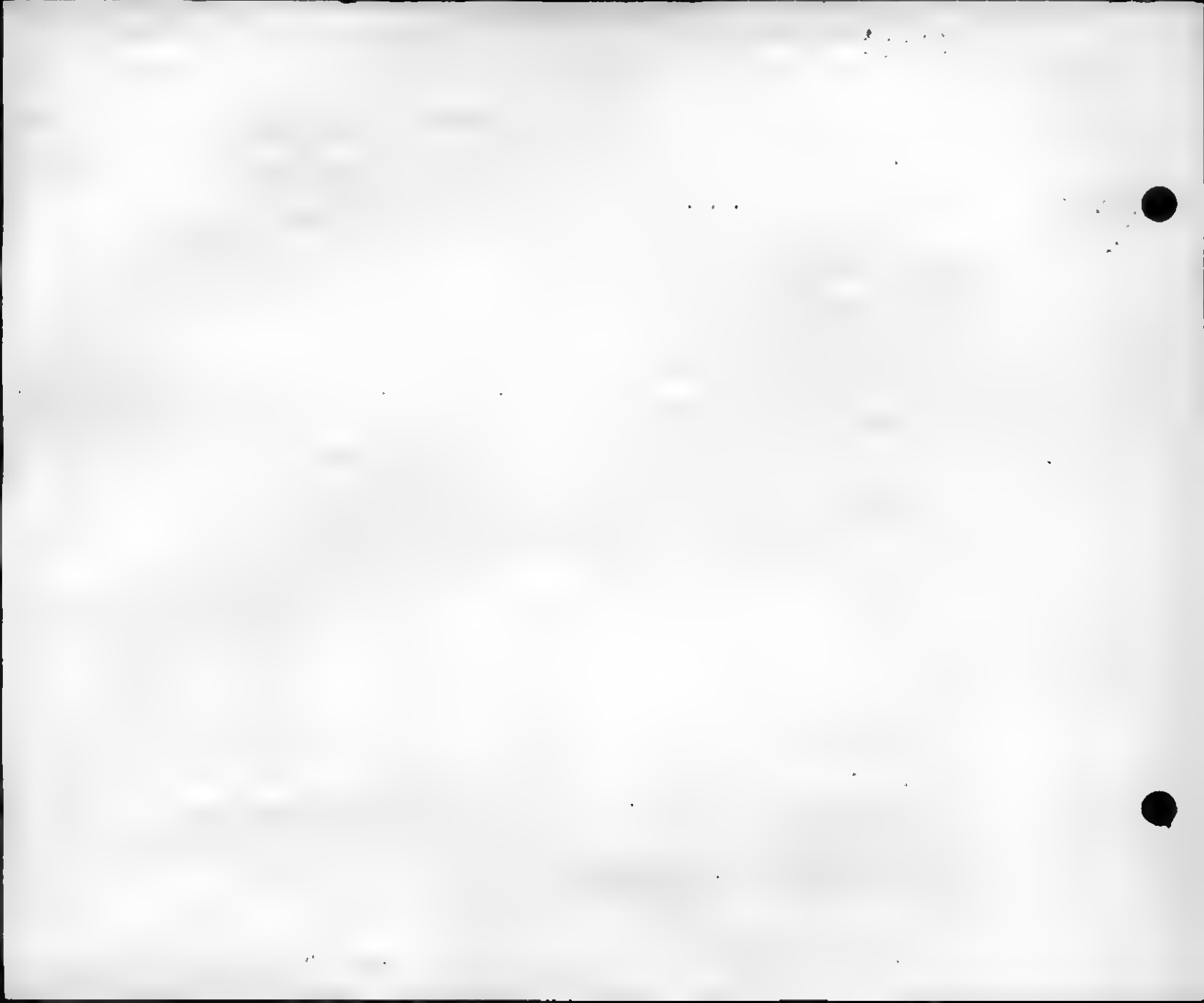
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15554

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15566

| | | | | | | | |
|---|-----------------|---|--|--|---|---|--|
| 1 DECEASED NAME (Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 11 1 1968 | | 2b HOUR 9:40a |
| EARL | | DEANE | | HARRINGTON | | | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH May 24, 1906 | 6 AGE (in years last birthday) 62 YRS | 7 UNDER YEAR MONTHS DAYS HOURS MIN. | 2c DATE PRONOUNCED DEAD Month Day Year November 1 1968 | 2d HOUR 9:40a | |
| 7a BIRTHPLACE (State or foreign country) Michigan | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH Balto. Md. | | |
| 10 CITY OR TOWN OF DEATH Balto. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1121 Elmridge Ave. | | 12a JSJAL OCCUPATION (Kind of work done during most of working life, even if retired.) Semi Retired | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USJAL RESIDENCE (Where deceased lived, if institution admission) STATE Md. | | 13b COUNTY Balto. | | 13c CITY OR TOWN Balto. | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER 1121 Elmridge Ave | |
| 14 FATHER'S NAME First Middle Last William Harrington | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ivy Henshaw | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT ADDRESS Mrs. Myrtle E. Harrington, 1121 Elmridge Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 443X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D. | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b DATE SIGNED November 1, 1968 | |
| 23a BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b DATE 11-5-1968 | | 23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 23d LOCATION (City or Town) (County) (State) Homer, Michigan | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | 25a. REC'D BY REGISTRAR DATE NOV 6 1968 | | 25b REGISTRAR'S SIGNATURE J Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1/68

15555

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15555

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Thomas</i> | | First <i>R.</i> | | Middle <i>H.</i> | | Last <i>Haviland</i> | | 20. DATE OF DEATH <i>Nov.</i> Month <i>15</i> Day <i>1968</i> Year | | | | 2b. HOUR <i>7 A.M.</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>August 5, 1922</i> | | | | 6. AGE (In years last birthday) <i>46</i> YRS. | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St. Joseph Hospt.</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Balto. County Police</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Bureau</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Reisterstown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>Rt. 3 Box 150 Hanover Rd.</i> | | | | | |
| 14. FATHER'S NAME | | First <i>Michael</i> | | Middle <i>H.</i> | | Last <i>Haviland</i> | | 15. MOTHER'S MAIDEN NAME | | First <i>Mamie</i> | | Middle <i>Parks</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give date and grades of service) <i>WW 2</i> | | 16b. SOCIAL SECURITY NO. <i>219-03-1901</i> | | 17. INFORMANT <i>Mrs. Bertha R. haviland</i> | | | | Address <i>Reisterstown, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>11:10</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>H</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 2</i> , 19 <i>68</i> , to <i>November 15, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Nov 5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>C. E. McWilliams M.D.</i> | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS <i>Reisterstown, Maryland 21136</i> | | 22e. DATE SIGNED <i>11-16-68</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Nov. 18, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lane View Memorial</i> | | 23d. LOCATION (City or Town) <i>Carroll Co. Md.</i> | | (County) | | (State) | | | |
| 24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <i>NOV 18 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles J. J.</i> | | | | | |

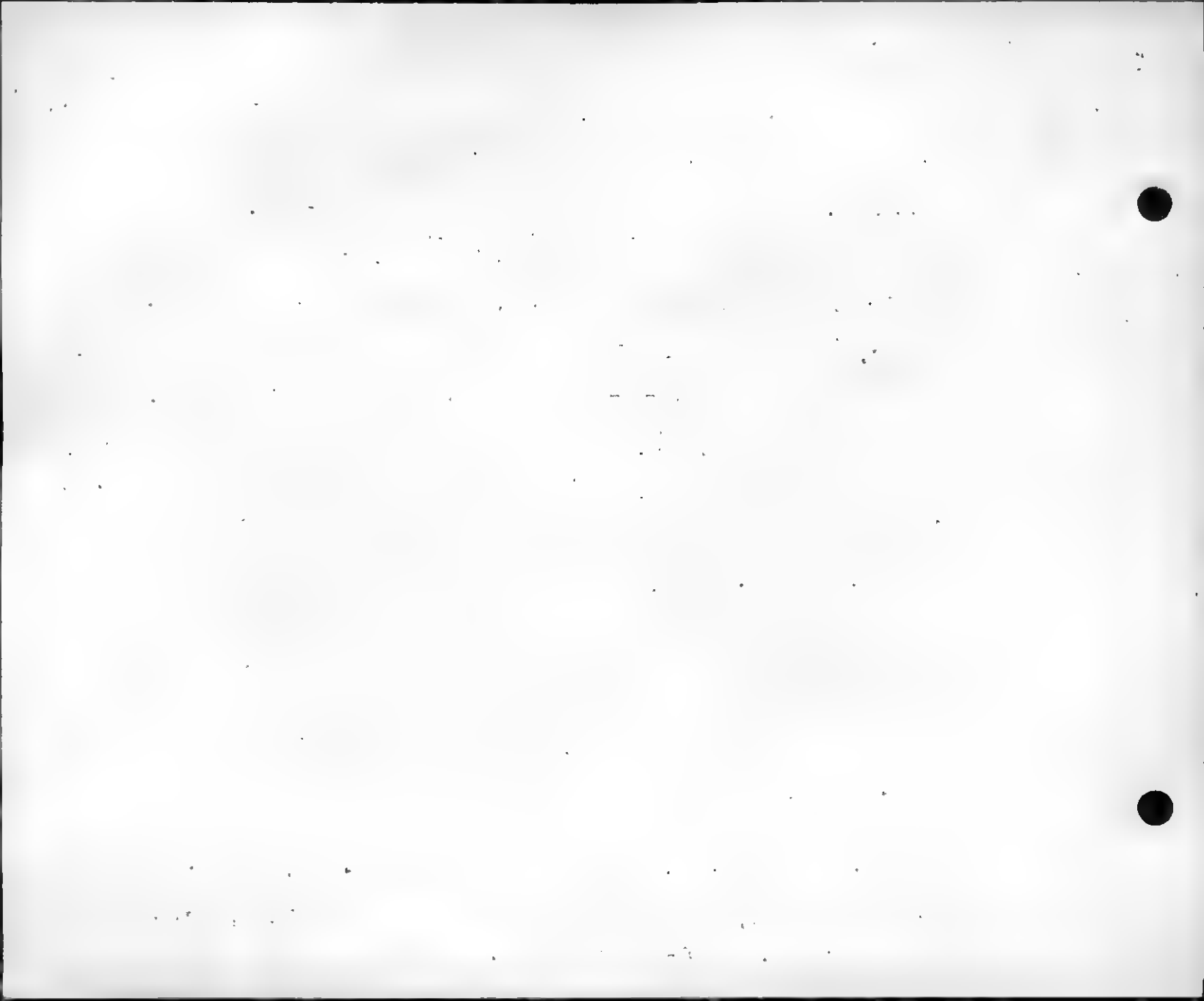


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|--|--|--|
| 155558 | | | | | | 155558 | | | | | | |
| 1. DECEASED-NAME (Type or print) George H. Heckwolf | | | | | | 2a. DATE OF DEATH Month 11 Day 8 Year 1968 | | | 2b. HOUR A 8:30 M | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 11/13/85 | | | 6. AGE (In years last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS 7 DAYS 1 | | IF UNDER 24 HRS. HOURS 1 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Balto. Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hosp. Towson, Md. 21201 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk B&O RR | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY Balto. 3806 Hudson St. | | | | | | 13b. CITY OR TOWN Balto. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 3806 Hudson St. | | |
| 14. FATHER'S NAME First George Middle Heckwolf Last | | | | 15. MOTHER'S MAIDEN NAME First Elizabeth Middle Leidig Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO 705-03-4912 | | 17 INFORMANT Address Rita F. MacNiven Stella Maris Hosp. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death of Senor Lage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 330 x (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/3 3 days Chronic | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterial aneurysm | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/8 , 19 68 , to 11/8 , 19 68 , that (I) (we) lost the deceased alive on 11/8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE J. David Nagel | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/8/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) J. David Nagel, M. D. | | | | | | 22e. ADDRESS Courthouse Sq. Apts. Towson, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-11-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave. | | | | | | 25a. RECD BY REGISTRAR DATE NOV 12 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

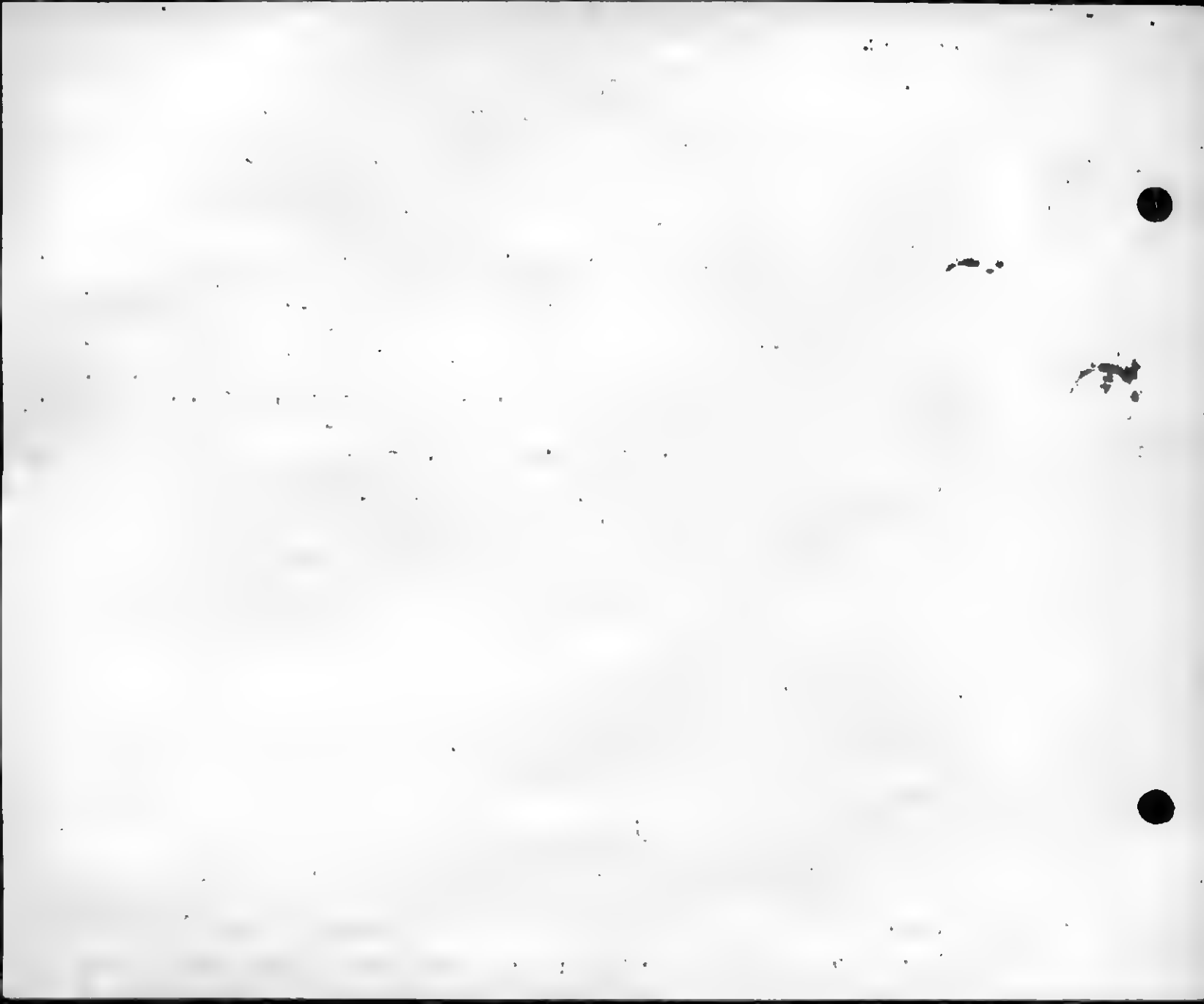
15557

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15557

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) Marie | | First Marie Middle E. Last Hensel | | 2a. DATE OF DEATH Month 11 Day 12 Year 1968 | | 2b. HOUR 12:45 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 10-1-95 | | 6. AGE (In years last birthday) 73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Balto. | |
| 10. CITY OR TOWN OF DEATH Garrison | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Folkleigh Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First John Middle Stumpf Last | | 15. MOTHER'S MAIDEN NAME First Anna Middle Odd Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16b. SOCIAL SECURITY NO 215-54-1937 | | 17. INFORMANT (Niece) Address Balto. Md. Mrs. Marie Kendzejeski, 803 S. Belnord Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1750 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-11 , 19 68 , to 11-12 , 19 68 , that (I) (we) last saw the deceased alive on 11-12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE David L. Miller | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-12-68 | |
| 22d. PHYSICIAN'S NAME (Type) David L. Miller | | 22e. ADDRESS 9115 Reisterstown Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md. | | | | 25a. REC'D BY REGISTRAR DATE NOV 15 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

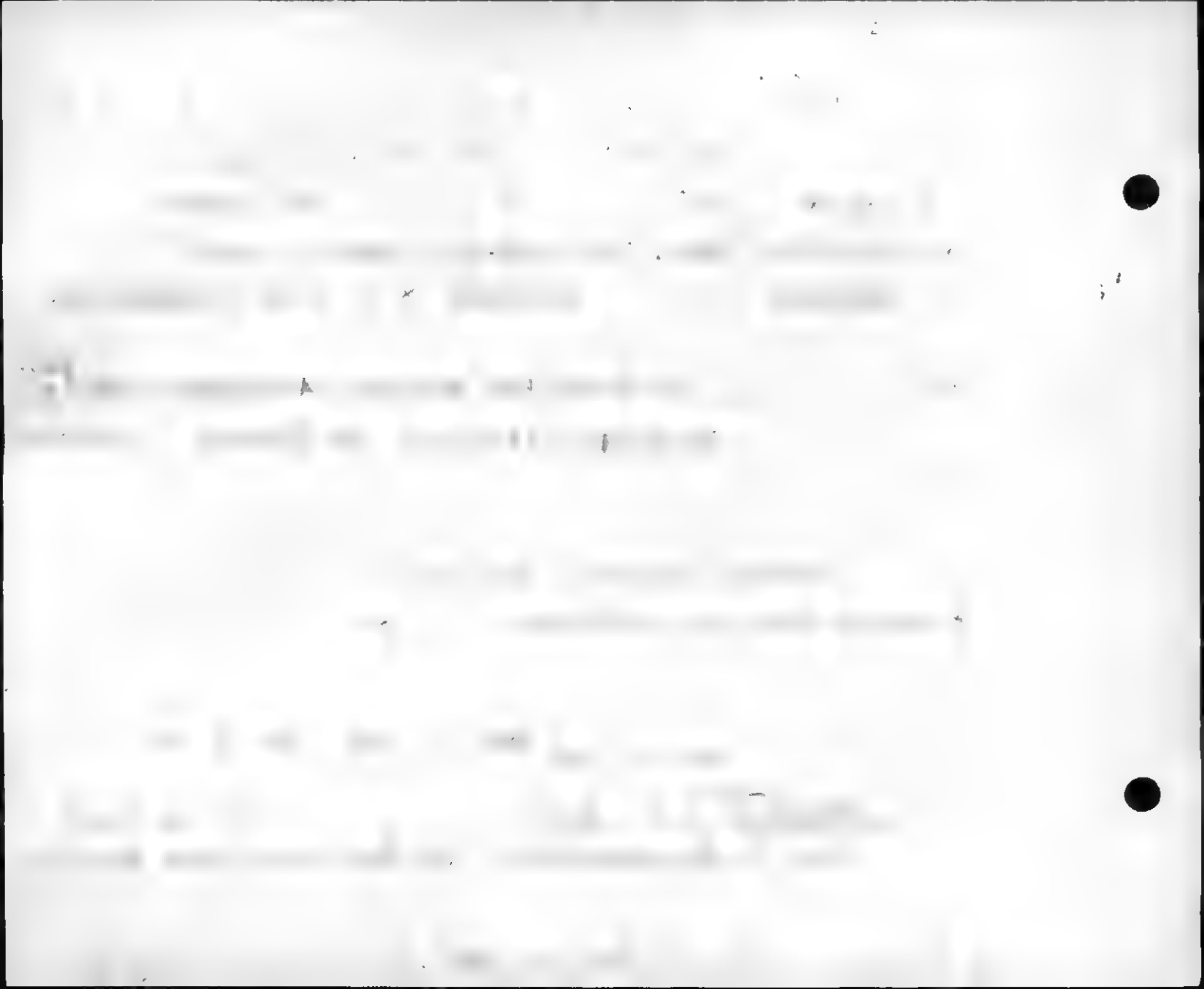
MEDICAL CERTIFICATION



| | | | | | | | | | |
|--|---------|---|------------------|--|---------------------------------|--|-----------------------|--|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| IDA | | n.m.v. | | HILL | Month 11 Day 9 Year 68 | | 7:25PM | | |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | | |
| F | NEGRO | | 6-15-01 | | 67 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| So. CAROLINA | | U.S. | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| RANDALLSTOWN | | BALT. COUNTY GEN. HOSP | | DOMESTIC HELP | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | | BALTIMORE | | | | 4200 RIDGEWOOD AVE. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| JOHN JENKINS | | NANCY JENKINS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | |
| | | 139-26-5009 | | MRS. ANNA YOUNG | | 4200 RIDGEWOOD AVE. BALT. MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF STOMACH | | | | | | | | UNKNOWN | |
| 1519 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 1 Cerebrovascular Accident | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| C. MAY 1968 | | CARCINOMA OF STOMACH | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory) (Off of building, etc.) | | 21f. LOCATION Street or R.F.D. no City or Town County State | | | | | |
| Where <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. 2, 1968, to NOV. 9, 1968, that (I) (we) last saw the deceased alive on NOV. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | |
| JOEL A. MALABRIGO, M.D. | | | | | | | | 11-9-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | |
| JOEL A. MALABRIGO, M.D. | | | | | | | | c/o BALT. COUNTY GEN. HOSPITAL | |
| 23a. BURIAL CREMATION | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/14/68 | | FAIRLAWN CEMETERY | | FAIRLAWN NJ. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| J. B. Johnson | | Eutam PI Baltimore, Md | | NOV 13 1968 | | J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

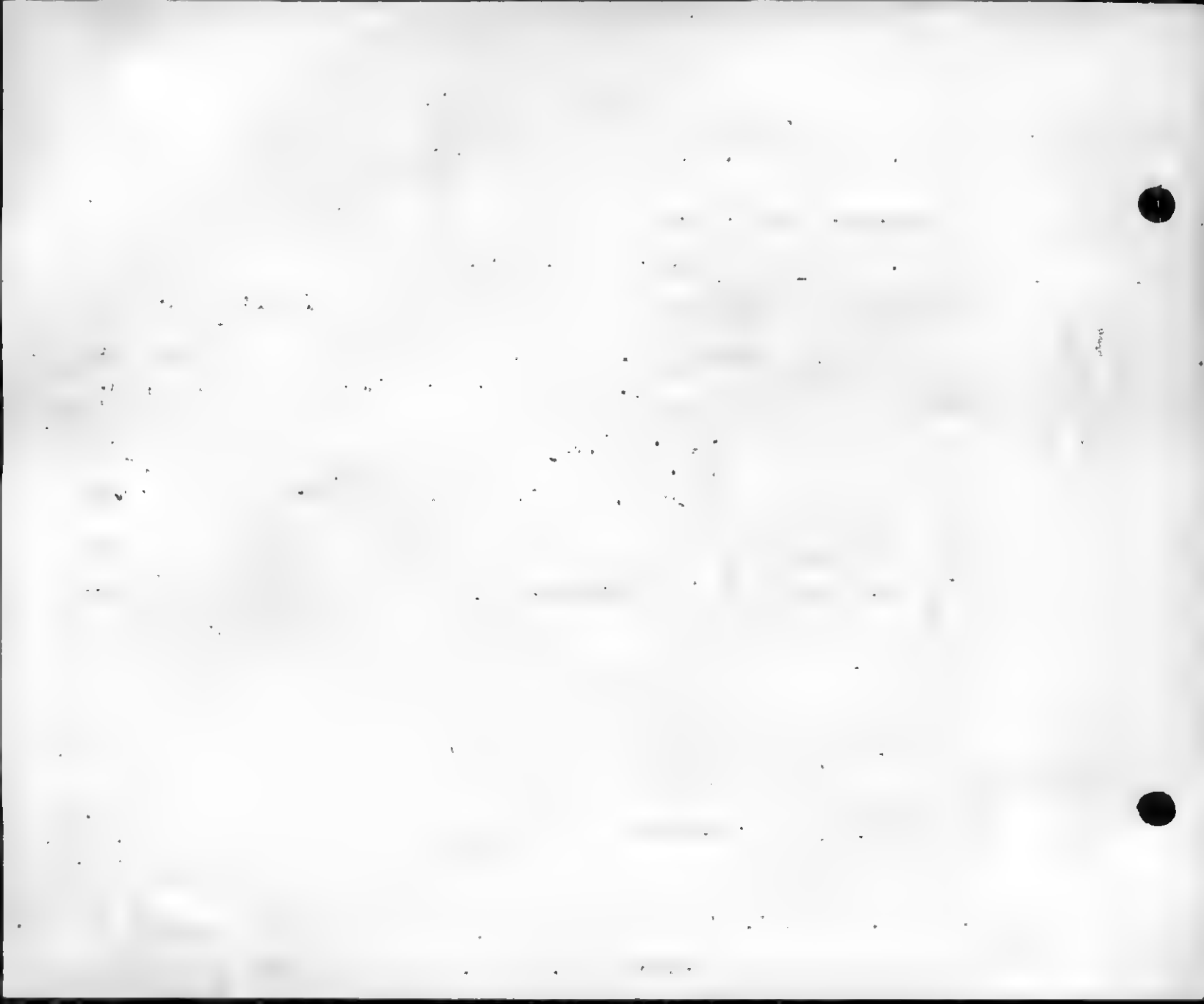


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (4)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last CHRISTINA SUSANNE HINRICHS Christina Susanne Hinrichs | | | 20. DATE OF DEATH Month Day Year 11 2 63 | | 2b HOUR 9 a M | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH 3/28/60 | | 6. AGE (in years lost birthday) 8 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Balto. Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Owings Mills Balto. Co. Md. | | | |
| 10 CITY OR TOWN OF DEATH Balto. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | 13b. CITY Baltimore | | 13c. CITY OR TOWN Ruxton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 1308 Circle Road | |
| 14 FATHER'S NAME First Middle Last Ernest Henry Hinrichs Jr. | | | 15 MOTHER'S MAIDEN NAME First Middle Last Susanne Scheffer Hinrichs | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO none | | 17 INFORMANT Address Rosewood Records Owings Mill, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of Stomach Contents DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 3448 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unusual Unusual | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Encephalopathy Post Pneumococcal Meningitis 7 yrs | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/9, 1962 to 1/2, 1968, that (I) (we) last saw the deceased alive on 1/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard Jones | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED Nov 68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Richard Jones | | 22e. ADDRESS Carroll County Hospital Westminster, | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Nov. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md. | | | |
| 24 FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., Balto. | | ADDRESS 21201 | | 25a. REC'D BY REGISTRAR DATE NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15572

15560

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (Type or print) ETHEL | | | First Middle Last | | | 2a. DATE OF DEATH Month NOVEMBER Day 18 Year 1968 | | | 2b. HOUR 5:40 A.M. | | | | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) 79 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) LATVIA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 5429 JONQUIL AVENUE #21215 | | |
| 14. FATHER'S NAME First Middle Last ? CHIEN | | | 15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates at service) | | | 16b. SOCIAL SECURITY NO NO | | | 17. INFORMANT MR. JEROME HONKOFSKY, 3711 PIMLICO RD. #21208 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 years coronary artery disease 4/10/68 DUE TO, OR AS A CONSEQUENCE OF coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4/10/68 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12/19 to 11/18/68 , that (I) (we) last saw the deceased alive on 11/15/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Milton B. Kirsh | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 11-18-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. MILTON B. KIRSH | | | | | | 22e. ADDRESS 4000 W. NORTHERN PARKWAY | | | | | | | | |
| 23a. BURIAL OR CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 11-19-68 | | | 23c. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL | | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | 25a. REC'D BY REGISTRAR NOV 20 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15561

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|---|-------------------------------|--|
| 1. DECEASED-NAME (Type or print) ^{First} Margaret ^{Middle} A. ^{Last} Hook | | | 2a. DATE OF DEATH 11 Month 12 Day 68 Year | | | 2b. HOUR 6.40p | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 12-1-90 | | 6. AGE (In years last birthday) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County Md | | | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore Balto | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER 813 Templeclift Rd. | | |
| 14. FATHER'S NAME ^{First} Matthew ^{Middle} ^{Last} Flynn | | | 15. MOTHER'S MAIDEN NAME ^{First} Mary ^{Middle} ^{Last} Smith | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) | | | 16b. SOC. SEC. NO. 220-14-0764 | | | 17. INFORMANT Mr. Richard Hook, 813 Templeclift Rd | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarct-</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>CORONARY Heart Disease - coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YRS</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diffuse pulmonary edema</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE <u>Simon Calle, MD</u> ^{PATHOLOGIST} DEGREE | | | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Nov. 15, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | | 23d. LOCATION (City or Town) <u>Baltimore</u> | | (County) | | (State) <u>Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Frank H. Howell, Baltimore Md</u> | | | | | | 25a. REC'D BY-REGISTRAR <u>Nov 19 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 3 film 4 410

3/7/68

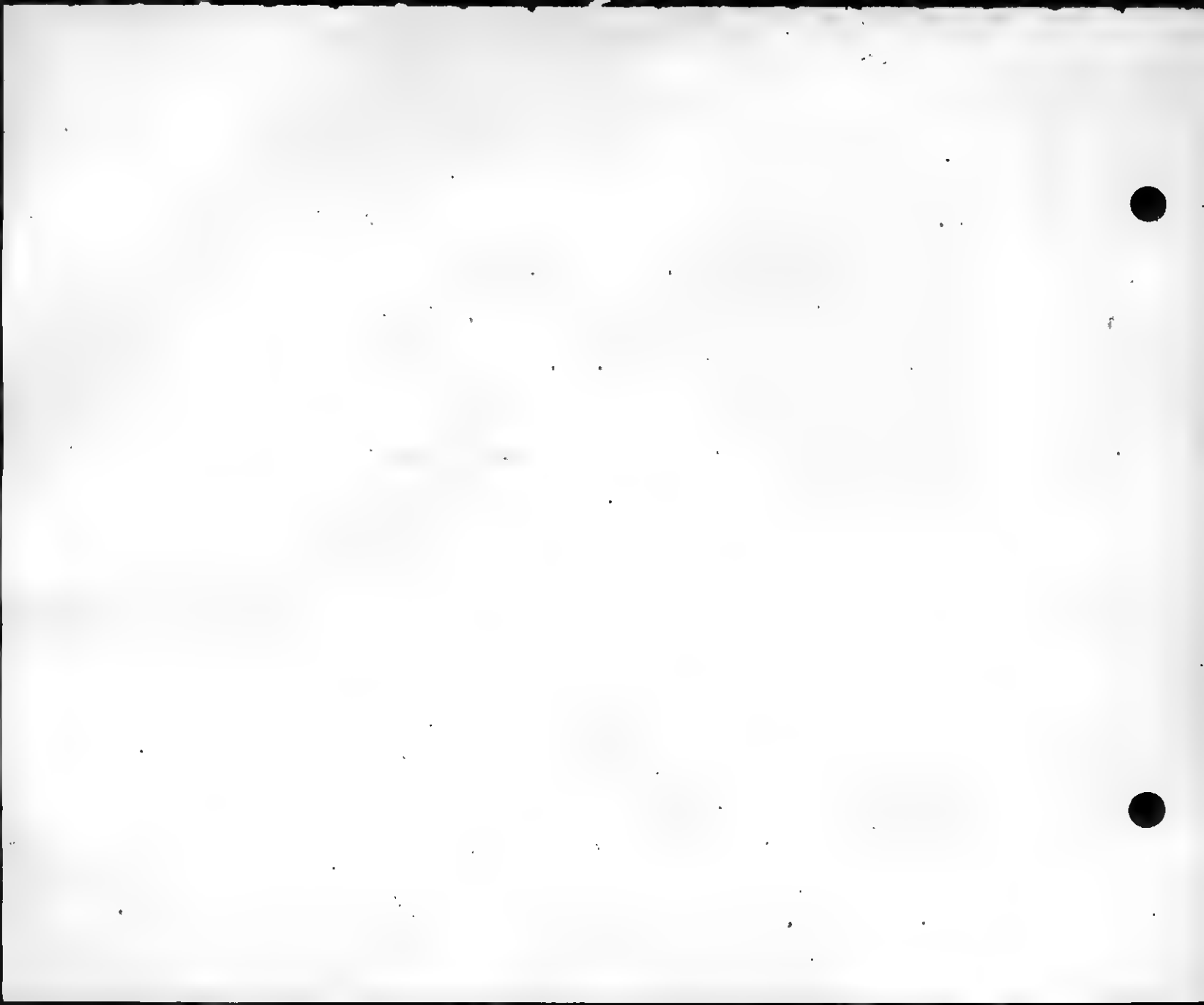
15568

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN ID | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph's Hospital</u> | | | | d. STREET ADDRESS <u>111 Belmore Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur D. David Horsman</u> | | | | 4. DATE OF DEATH Month Day Year <u>November 25, 1968</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 21, 1929</u> | 9. AGE (in years last birthday) <u>39</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>C & P Tel. Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>111</u> | | 17. INFORMANT <u>Family records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 101.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1960</u> to <u>Nov 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 21, 1968</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Laurence C. Post</u> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u> | |
| 22d. ADDRESS <u>6805 York Rd. - Baltimore 21212 Md</u> | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 27, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 27 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the funeral director. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Marie A. Huber | | | | | | 11 Month 1 Day 1968 | | 12:50 PM | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | 7/19/1879 | | 89 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Tyrol Austria | | U.S. | | | | Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | | Stella Maris Hospice | | | Childs Nurse | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | | Baltimore | | | Towson Balto. | | 13e. STREET AND NUMBER 4111 LaSalle Ave Dulaney Valley Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Johann Amort | | | Katherine Eller | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No | | | 16b. SOCIAL SECURITY NO. 212-32-1447R | | | 17. INFORMANT Mrs. T. R. Slingluff 4414 Norwood Rd. Balto. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary embolism 4129 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Suspect embolism or hyperlipidemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/27, 1968, to 11/1, 1968, that (I) (we) lost saw the deceased alive on 11/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. J. David Nagel | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11-1-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. J. David Nagel | | | | 22e. ADDRESS 812 Mockingbird Lane | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 11/4/68. | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. | | | | ADDRESS Balto. 21214 | | 25a. REC'D BY REGISTRAR DATE NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

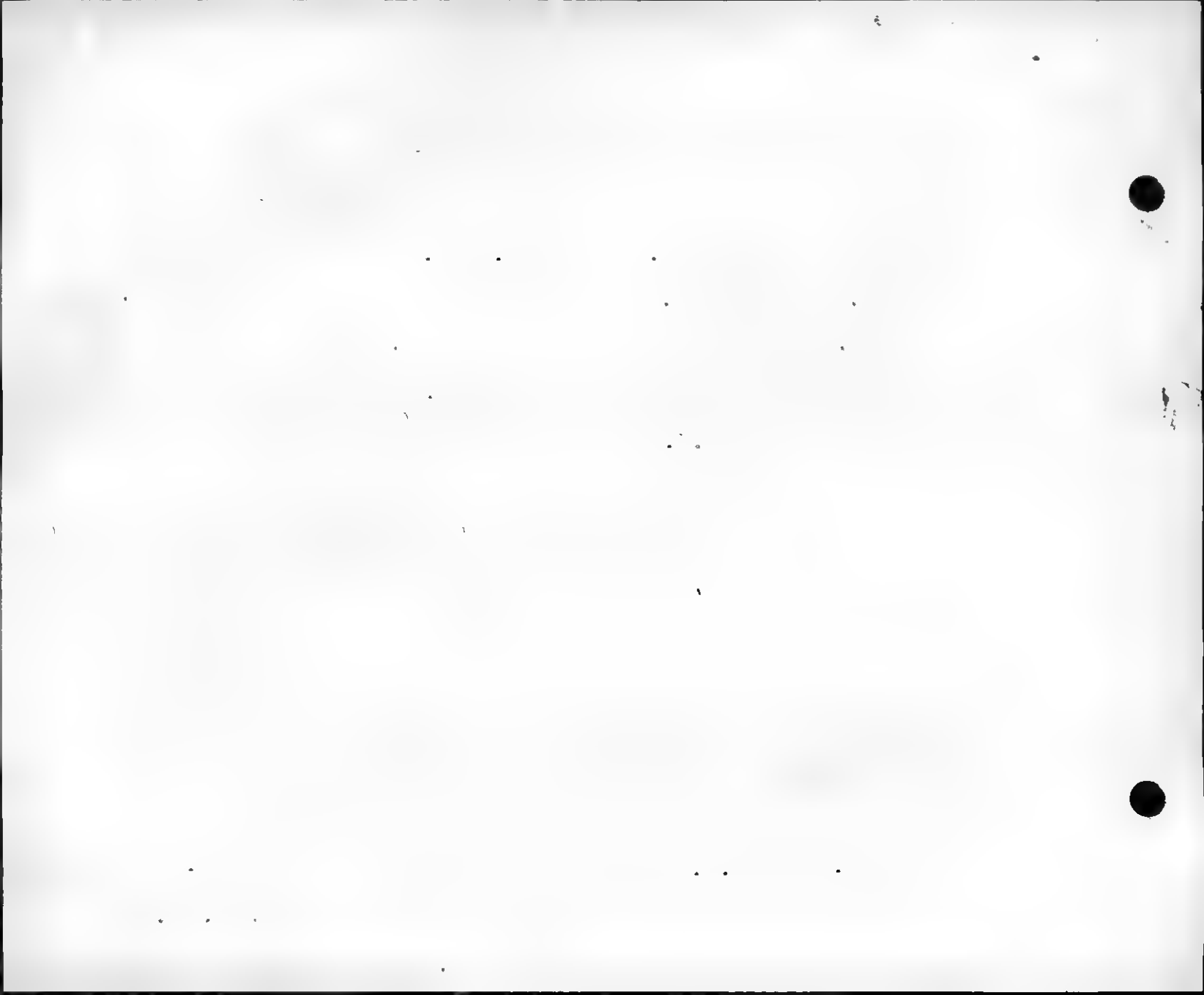
Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

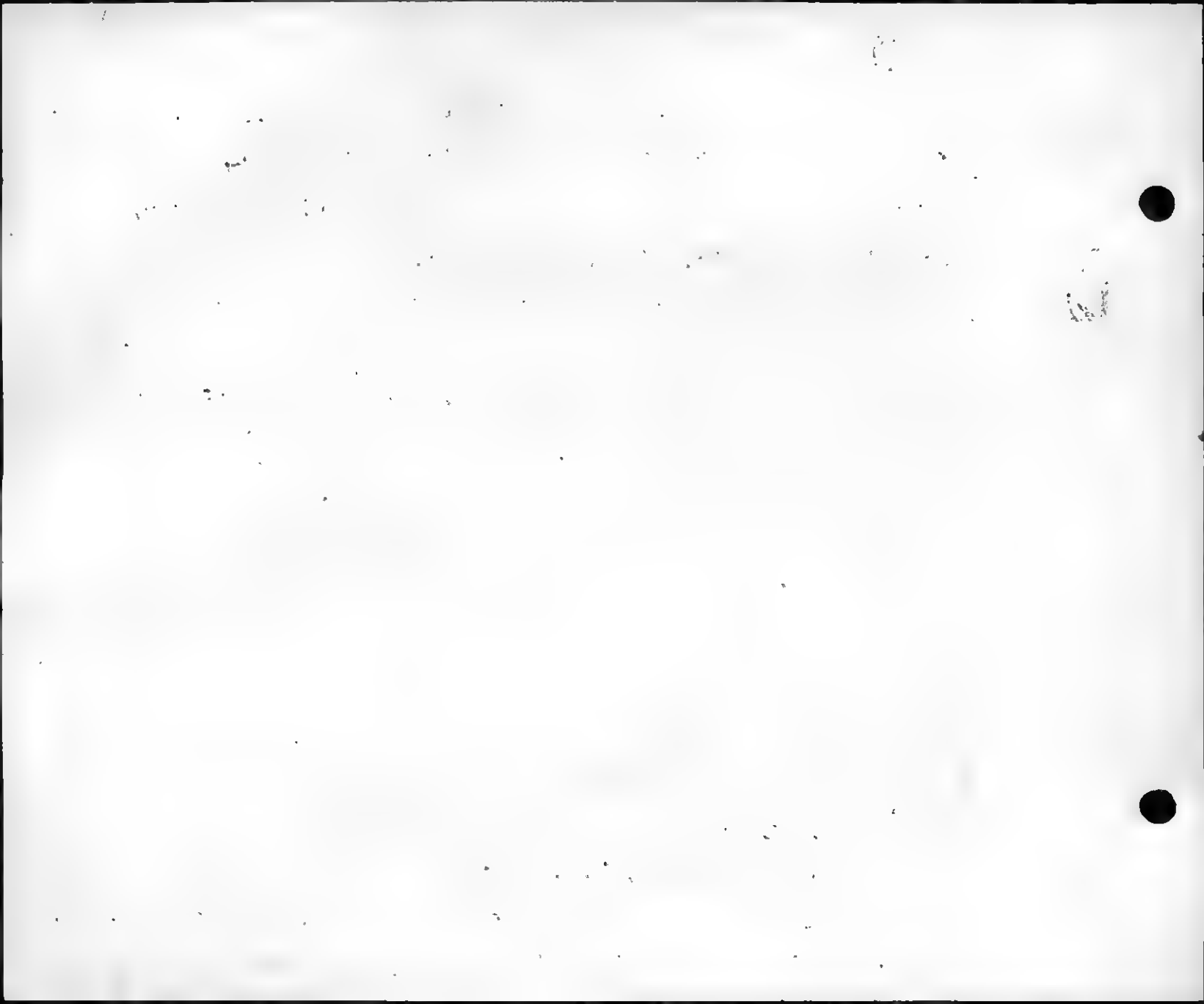
| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 15564 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15576 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1 DECEASED-NAME (Type or print) DAVID LEE HUGHES | | | 2a. DATE OF DEATH Month 11 Day 14 Year 68 | | | 2b. HOUR 7 p. M. | |
| 3 SEX MALE | | 4 RACE CEUCASIAN | | 5 DATE OF BIRTH 10-30-49 | | 6 AGE (In years lost birthday) 19 YRS. | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH BALTIMORE Md. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b COUNTY Balto. | | 13c CITY OR TOWN Parkville | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e STREET AND NUMBER 7709 Park Drive. 21234 | | 14. FATHER'S NAME First Donald G. Middle Hughes Last Hughes | | 15 MOTHER'S MAIDEN NAME First Ruth P. Middle Yeager Last Yeager | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO. 212 48 5349 | | 17. INFORMANT Donald G. Hughes | | Address 7709 Park Drive 21234 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) MULTIPLE HEMORRHAGES OF SKIN, | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) G.I. TRACT, SUBARACHNOID SPACE. | | | | | | | |
| 1991 DUE TO, OR AS A CONSEQUENCE OF (b) THROMBOCYTOPENIA AND BLEEDING PEPTIC ULCER | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) MENINGEAL SARCOMA OF POSTERIOR FOSSA WITH 11 MO | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) METASTASES | | | | | | | |
| STEROID THERAPY, RADIATION THERAPY | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/13, 1968 , to 11/14, 1968 , that (I) (we) last saw the deceased alive on 11/14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE C. C. Lin, M.D. DEGREE M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 11/14/68 | |
| 22d. PHYSICIAN'S NAME (Type) C. C. LIN, M.D. | | | | 22e. ADDRESS 6701 N CHARLES ST., BALT, MD | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) Burial | | 23b DATE 11-18-68 | | 23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d LOCATION (City or Town) (County) (State) Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR Johnson Funeral Home ADDRESS 8521 Loch Raven Blvd. | | | | 25a. REC'D BY REGISTRAR NOV 18 1968 | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15563 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15577 </div> | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--------|--|-------|-------------------------------|-------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First MARY | | | Middle HELEN | | | Last HUGHES | | | 2a. DATE OF DEATH Month Day Year 11-29-1968 | | | 2b. HOUR 235AM | | |
| 3. SEX Female | | | 4. RACE white | | | 5. DATE OF BIRTH 12/27/1894 | | | 6. AGE (In years last birthday) 73 YRS. | | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) MD. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore County, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp. | | | | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 1221 W. Baltimore St. | | | | | |
| 14. FATHER'S NAME | | | First Walter | | | Middle Hughes. | | | 15. MOTHER'S MAIDEN NAME | | | First Ester | | | Middle Miller. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. 213-26-0764 | | | 17. INFORMANT Records, Mt. Wilson State Hospital | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary TBC (mod. advanced)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia (terminal)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos. 1 wk. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | | State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/25/1968</u> , to <u>11/29/1968</u> , that (I) (we) last saw the deceased alive on <u>11/29/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>William Newcomer</u> | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12-2-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Balto. City, Baltimore Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | |

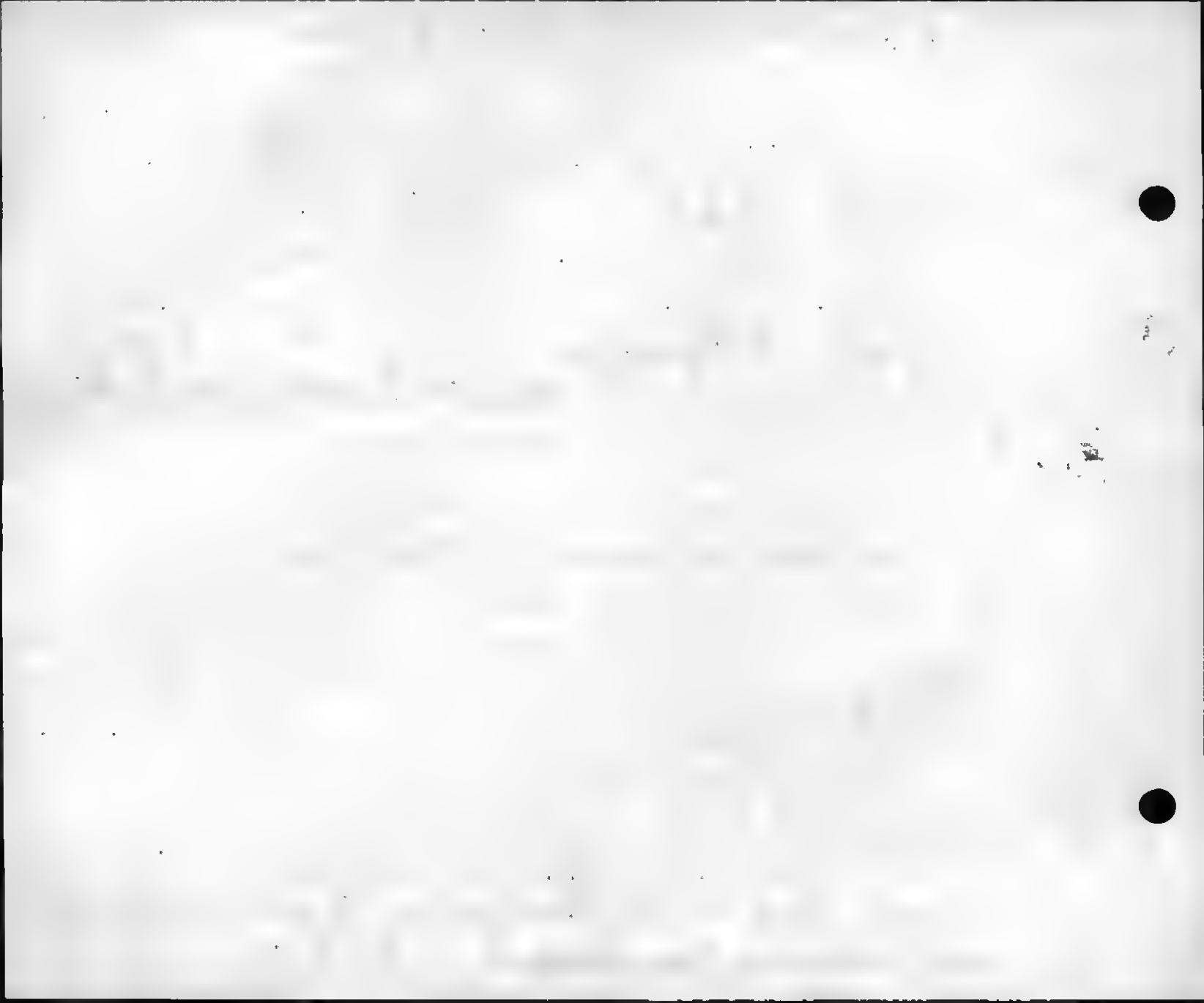


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, Item 20. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1001. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|---------|------------------------------|--|--|------|---|-----|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| RONALD WILSON HUMPHREY | | | | | | Month Day Year | | 2:15 PM | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | |
| Male | White | Oct. 10, 1965 | 3 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | 2d HOUR | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| York, Pa. | | U. S. A. | | | | Balto. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Parkton | | | Home of Dr. Mueller | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, first institution or residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | Balto. | | | Parkton | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Robert W. Humphrey | | | Carol A. Fahey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT ADDRESS | | | | |
| No | | | | | | Robert W. Humphrey, Parkton, Md. 21120 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture dislocation of neck.</u> | | | | | | | | | | |
| 880X DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| CAUSE OF DEATH | | | 1:30 AM 11 18 19 68 | | | Fell down stairs | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | Home | | | Parkton Balto. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | Nov. 18, 1968 | | | | |
| Edward F. Wilson, M.D. | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | | Nov 21, 1968 | | | Stablers Cemetery | | | Parkton, Balto., Md. | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| James J. Harten, New Freedom, Pa. | | | | | | NOV 21 1968 | | | Julian J. Judge | |

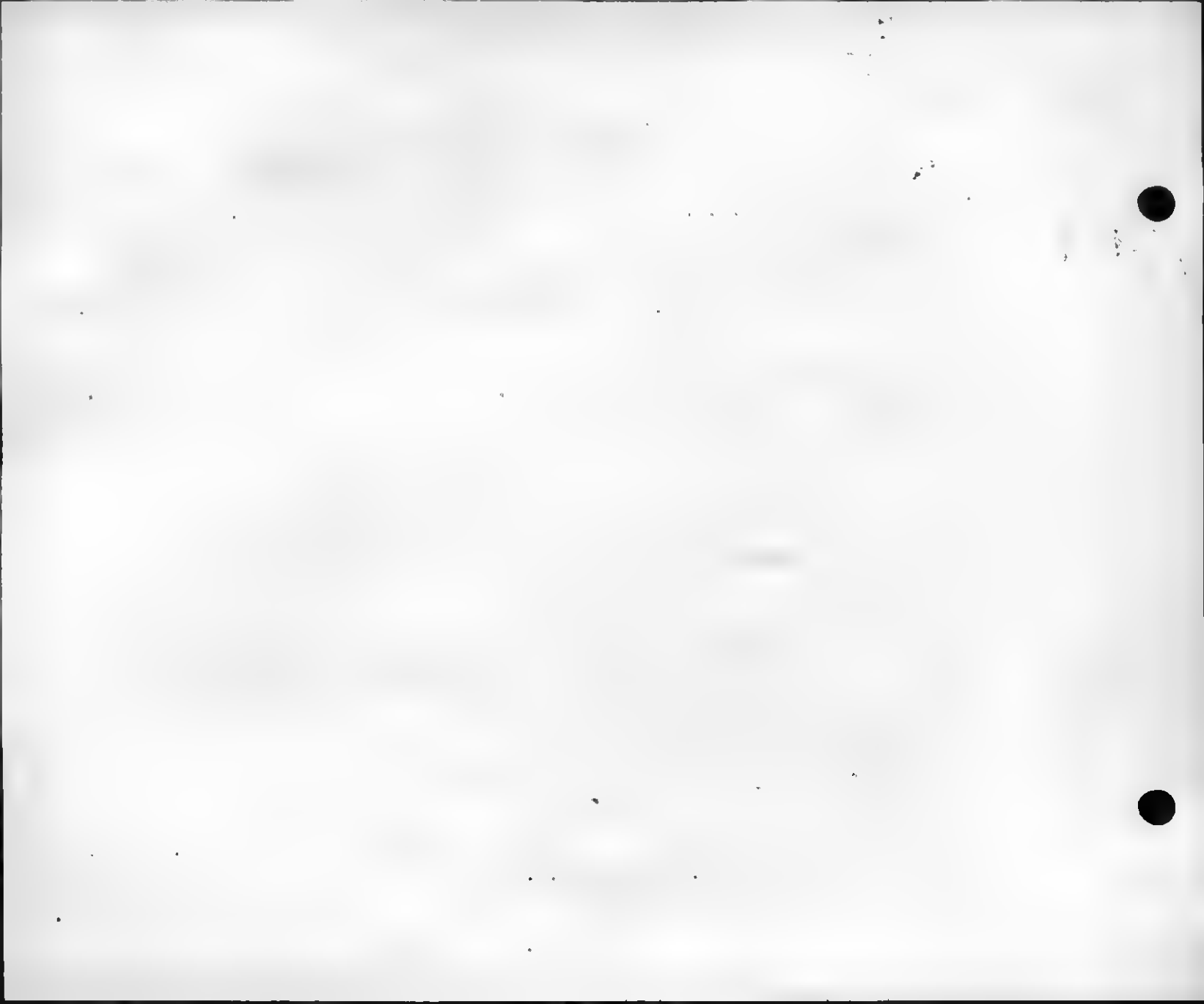


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the Health Department's Office. 5 may be retained for your files.

FOR STATE HEALTH DEPT.

15567

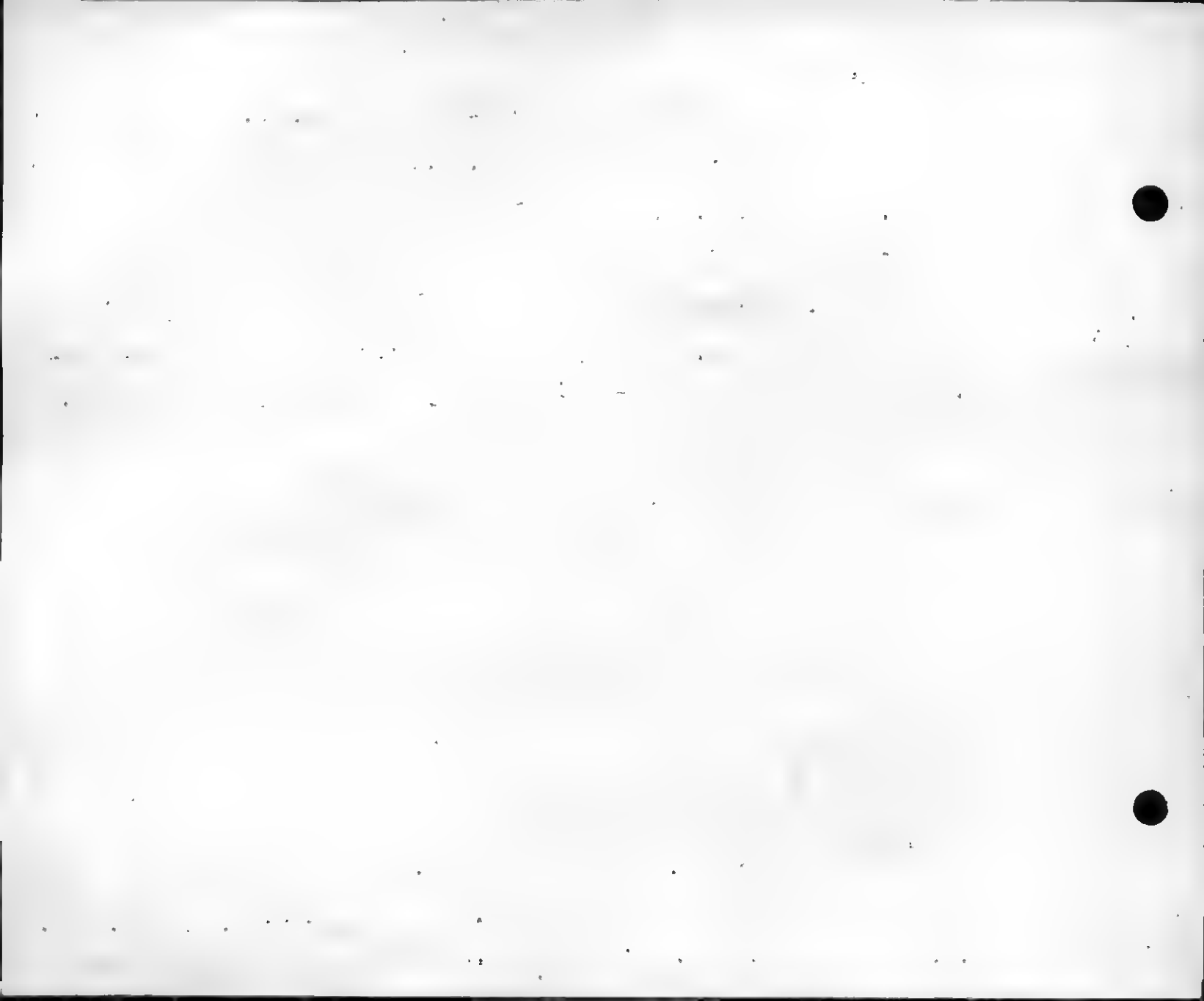
| | | | | | | | | |
|---|------------------------|--|--|---|--|---|---|---|
| 1. DECEASED NAME (Type or Print) First Middle Last TRACEY CATHERINE HUMPHREY | | | 2a. DATE KNOWN OF DEATH Month Day Year 11 21 1968 | | | 2b. HOUR 12:01 PM | | |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH 10/4/1912 | 6 AGE (In years) 56 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year November 21 1968 | | 2d. HOUR 12:01 |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Balto. | | |
| 10. CITY OR TOWN OF DEATH Woodlawn | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 722 Dogwood Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housework | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Woodlawn | | 13d. INSIDE CITY - M 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Box 722 Dogwood Rd. |
| 14. FATHER'S NAME First Middle Last Edward Howdysshell | | | 15. MOTHER'S MAIDEN NAME First Middle Last Nettie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) 218 22 4735 | | 17. INFORMANT ADDRESS Wm. E Humphrey Box 722 Baltimore 7, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION 11/23/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) | | | M.D. Edward F. Wilson, M.D. | | | 22b. DATE SIGNED Nov. 21, 1968 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd | | 23d. LOCATION (City or Town) (County) (State) Ellicott City Howard, Md. | |
| 24. FUNERAL DIRECTOR Wiginbotham Slack | | | | ADDRESS Ellicott City, Md. | | 25a. REC'D BY REGISTRAR NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Emily | | | Middle Riggs | | | Last Hundley | | | 2a. DATE OF DEATH Month Nov. Day 10, Year 1968 | | | 2b. HOUR 3 A. M. | | |
| 3. SEX F | | | 4. RACE W | | | 5. DATE OF BIRTH Jan. 18, 1895 | | | 6. AGE (In years last birthday) 73 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | | UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH Ruxton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 305 Greenwood Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e. STREET AND NUMBER Warrington Apts. | | | | | |
| 14. FATHER'S NAME First Jessie Middle B. Last Riggs | | | 15. MOTHER'S MAIDEN NAME First Charlotte Middle Symington Last Symington | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 212-10-5468D | | | 17. INFORMANT James W. Hundley, 305 Greenwood Rd. | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>immediate</u> <u>yes</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/10/68</u> , 19 <u>68</u> , to <u>11/10/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/10/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Francis W. Gluck M.D.</u> | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <u>11/11/68</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck | | | 22e. ADDRESS 100 W. University Pkwy. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/13/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Church | | | 23d. LOCATION (City or Town) (County) (State) Long Green, Balto., Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | ADDRESS 4905 York Rd. Balto., Md. | | | 25a. REC'D BY REGISTRAR NOV 13 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept of Health pr. or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15-11
30A REV. 1-68

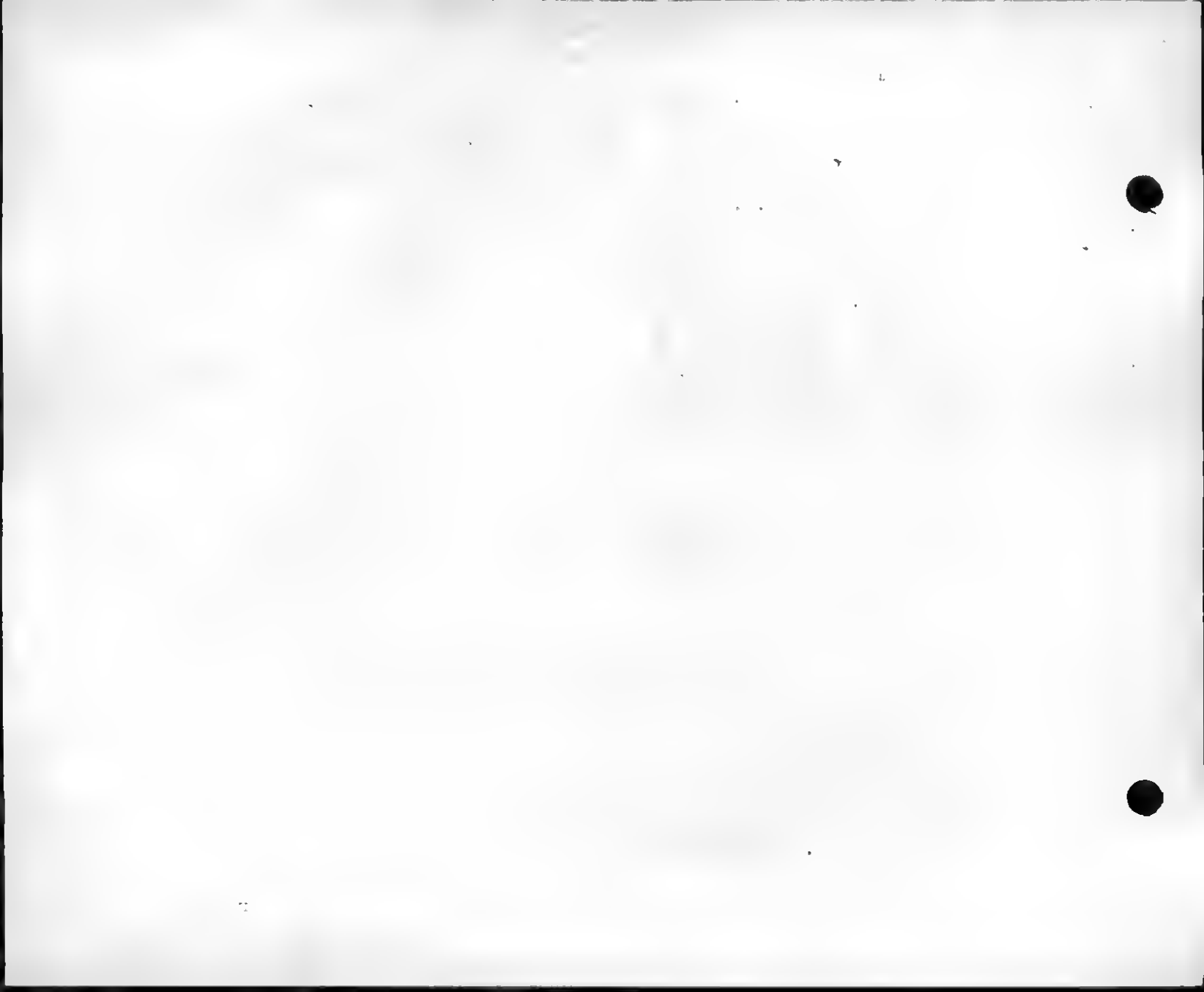
15569

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15581

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|--------------|
| 1. DECEASED-NAME (Type or print) Maud V. Hurley | | | 2a. DATE OF DEATH Nov Month 2 Day 1968 Year | | | 2b. HOUR 6:30 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Oct 22, 1878 | | | 6. AGE (In years lost birthday) 90 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) Washington | | 7b. CITIZEN OF WHAT COUNTRY? D.C. US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH Arbutus | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 928 Palladi Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 928 Palladi Drive | |
| 14. FATHER'S NAME First Middle Last Nathaniel Sweeney | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Martha McClough | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-01-5729 | | 17. INFORMANT Address Theresa E. Hurley, 928 Palladi Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertensive arteriosclerosis 6 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Senility undit. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ++ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from July 23, 1967 to Nov 2, 1968 , that (I) (we) last saw the deceased alive on Aug 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A. Bradley Daugharthy MD | | | | | 22c. DATE SIGNED Nov 3, 1968 | | 22d. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy | | |
| 22e. ADDRESS 1264 Francis Ave | | | | | 22f. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Burial) | | 23b. DATE 11/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. | | | | | 25. REC'D BY REGISTRAR DATE NOV 6 1968 | | 26. REGISTRAR'S SIGNATURE Charles Judge | | |

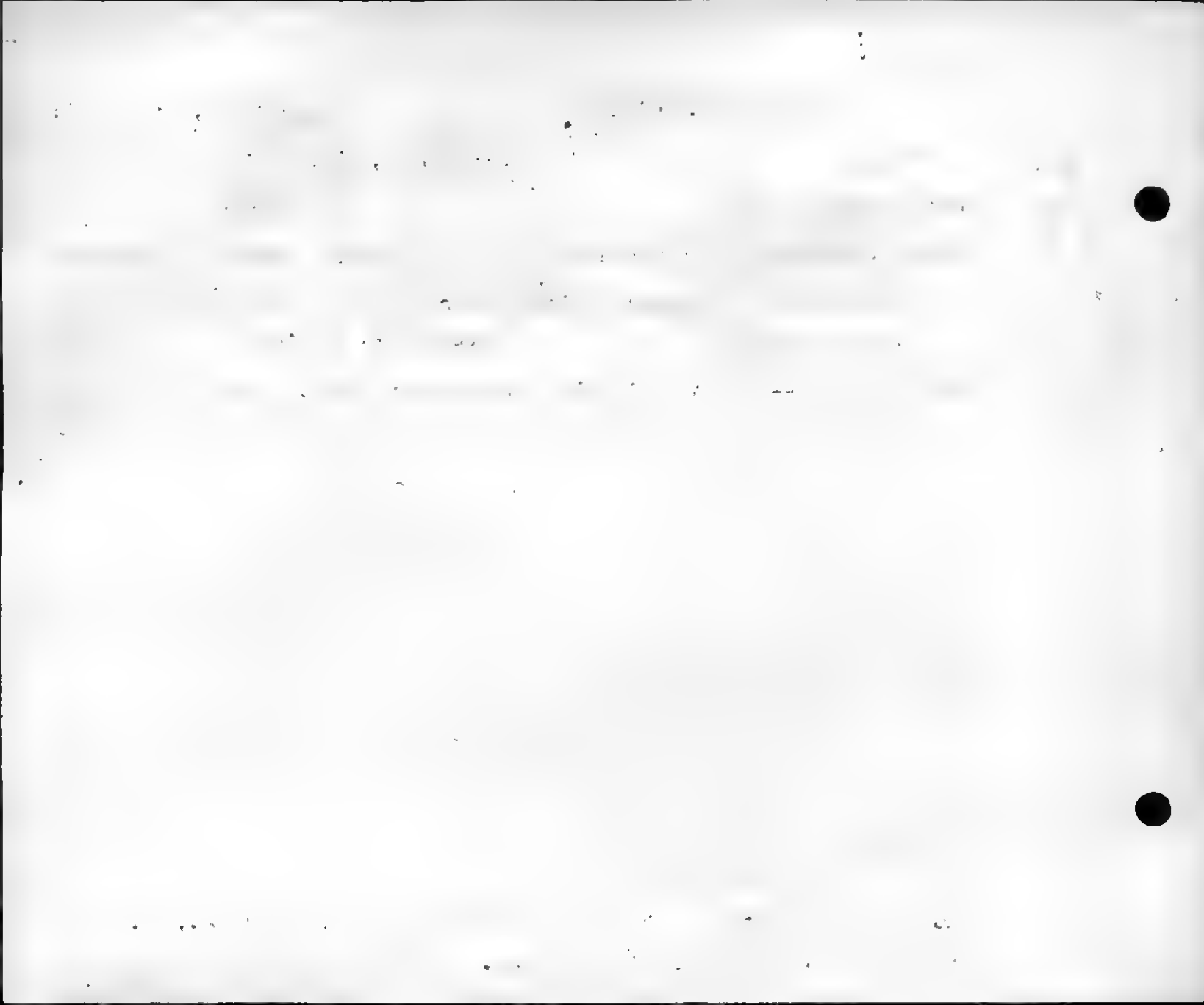


TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115 (1)
304 REV. 11/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15570 CERTIFICATE OF DEATH 15582 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last CHRISTINE E. HUTTON | | | 2a. DATE OF DEATH Month Day Year November 2, 1968 | | | 2b. HOUR 12:15 PM |
| 3. SEX Female | | 4. RACE CAU | | 5. DATE OF BIRTH December 31, 1920 | | 6. AGE (In years last birthday) 47 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 9. COUNTY OF DEATH Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH Wilson Point 21220 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 16 Elm Drive | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Assembly Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Aircraft | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Middle River | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 16 Elm Drive | |
| 14. FATHER'S NAME First Middle Last Robert Hawley | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lucille J. Hambrick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 233 20 4391 | | 17. INFORMANT Joseph Robert Hutton | | Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Living abdominal hernia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 8 1/2 hours |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9:07, 19</u> , to <u>11/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>J. Platt, M.D.</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/2/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) J. PLATT, M.D. | | | | 22e. ADDRESS E. 55th. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMAINS (Specify) Burial | | 23b. DATE 11/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home</u> | | | | 25a. REC'D BY REGISTRAR DATE NOV 6 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

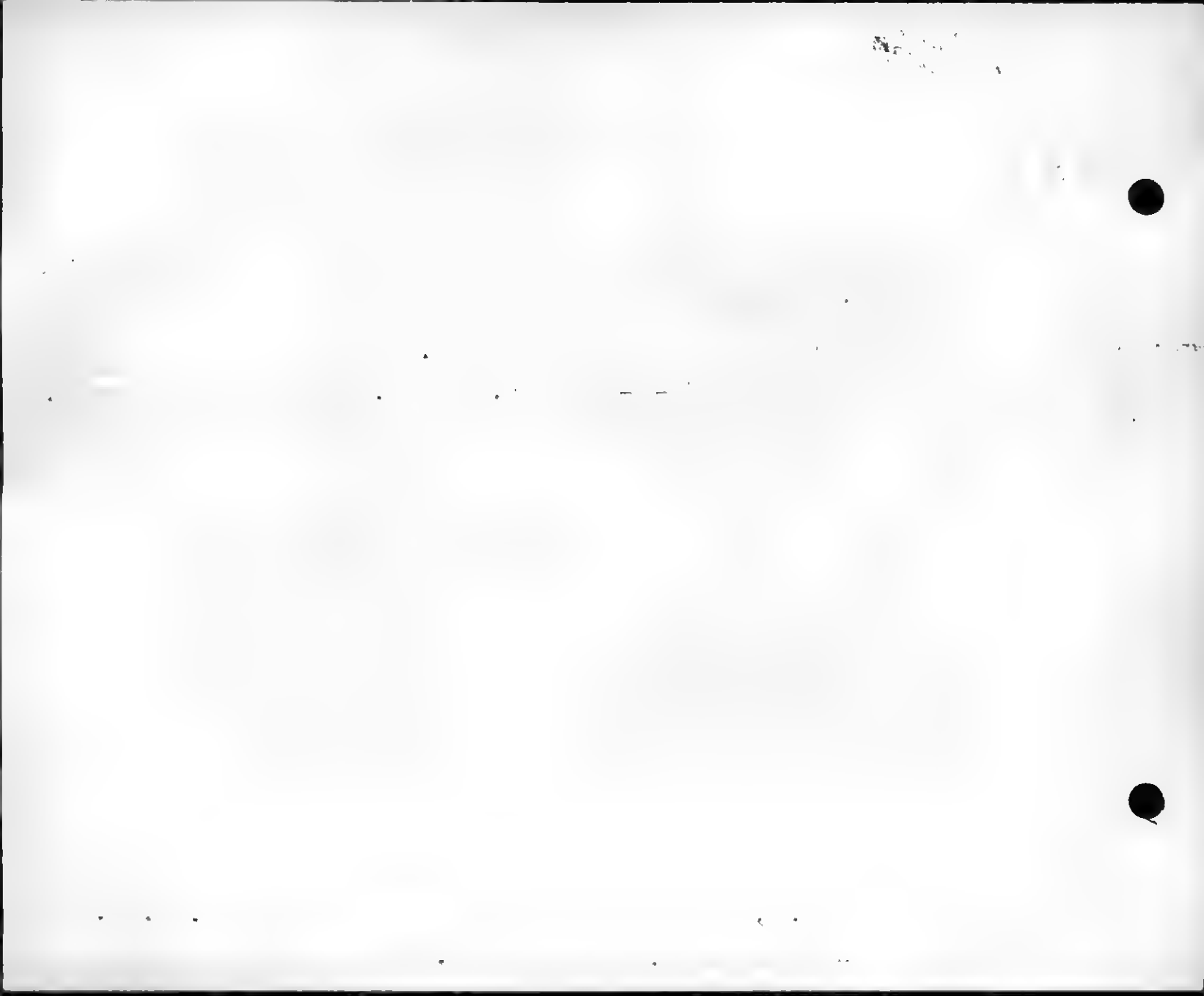
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15572

15583

| | | | | |
|---|--|---|---|--|
| 1. DECEASED NAME (Type or print) Emerson D. Insley | | 2a. DATE OF DEATH Month Nov Day 1 Year 68 | | 2b. HOUR 2:10 P.M. |
| 3. SEX male | 4. RACE White | 5. DATE OF BIRTH 3-28-09 | 6. AGE (In years lost birthday) 59 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Barco Co Gen Hosp | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Organizer | 12b. KIND OF BUSINESS OR INDUSTRY Teamsters Union | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | 13b. COUNTY Balto | 13c. CITY OR TOWN Balto | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 4105 Villa Nova Rd. |
| 14. FATHER'S NAME First Walter Thomas Middle Walter Last Thomas | 15. MOTHER'S MAIDEN NAME First Annie L. Middle Walter Last Thomas | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO 214-12-1530 | | 17. INFORMANT Address 21207 Mrs. Jeanne M. Insley 4105 Villa Nova Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per Part 1. Death was caused by: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 Diabetes Mellitus | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | 21f. LOCATION Street or R.F.D. No City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-28-68 , to 11-1-68 , that (I) (we) last saw the deceased alive on 11-1-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Gregorio Warren | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 11-1-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | |
| 23a. BURIAL CREMATION, REINTERMENT | 23b. DATE Nov. 4, 68 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md. | | 25a. REC'D BY REGISTRAR NOV 4 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



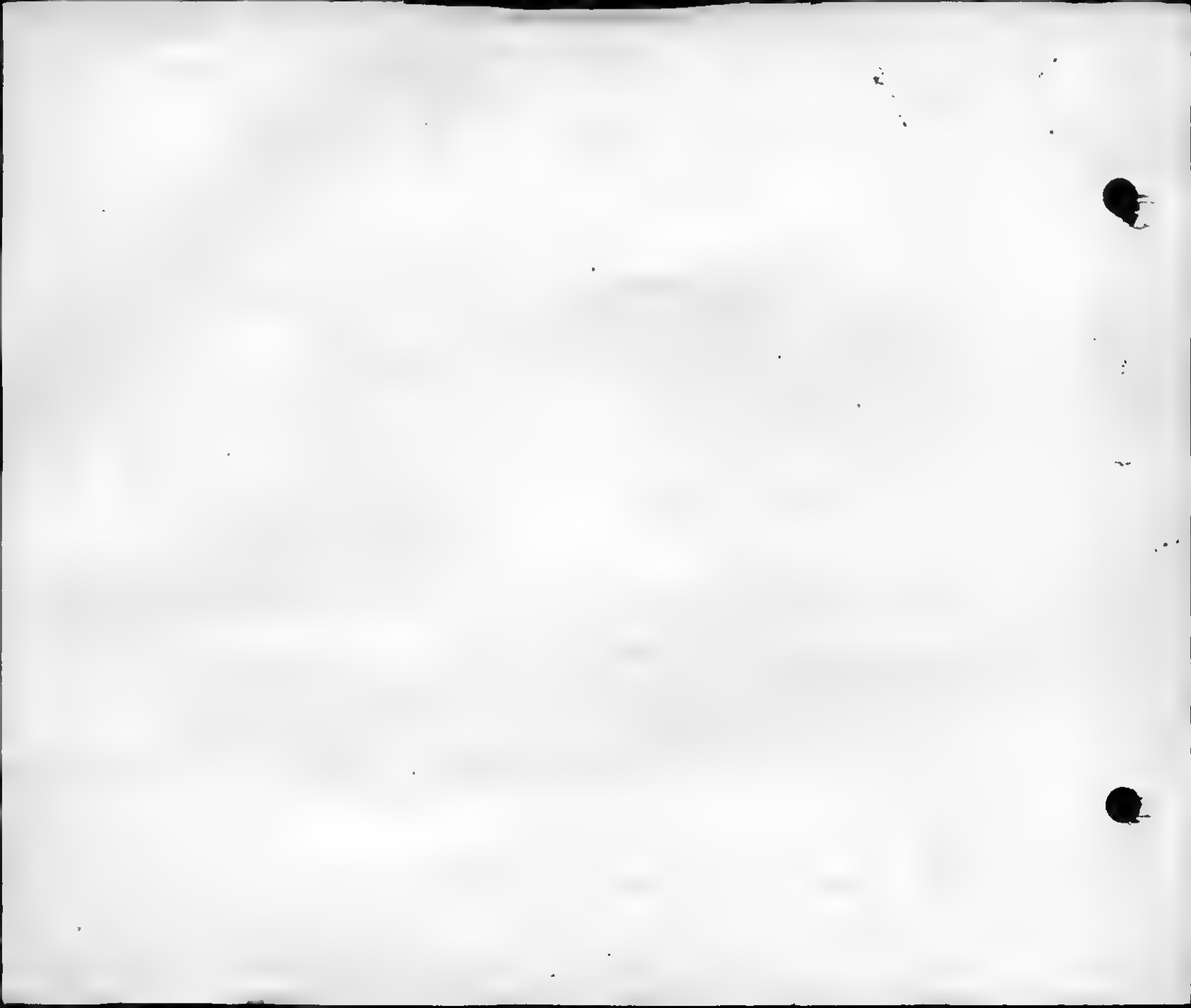
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 21204 | | c. LENGTH OF STAY IN 1b 21204 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1813 Ruxton Road | | d. STREET ADDRESS 1813 Ruxton Road | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle S. Last Jacobs | | 4. DATE OF DEATH Month November Day 23 Year 1968 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/31/1893 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months 7 Days 23 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Operators Heat - Coal Belair, Md. | | 11. BIRTHPLACE (State or foreign country) U. S. A. | |
| 13. FATHER'S NAME Frank H. Jacobs | | 14. MOTHER'S MAIDEN NAME Elizabeth Street | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-07-0742 | |
| 17. INFORMANT Bradford Jacobs, Box 8015, Ruxton, Md. | | Address 21204 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Gastrointestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). DUE TO (c). | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 57. Emphysema, severe | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958 to Nov. 23, 1968 , that I last saw the deceased alive on Nov. 23, 1968 , and that death occurred at 5:00 p.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W.B. Daniels, Jr. M.D. | | ADDRESS (Street, city or town, state) 11 E. Chase St. Baltimore 21202 | |
| PHYSICIAN'S NAME (Type) W.B. DANIELS, Jr. | | DATE SIGNED 11/23/68 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 11/26/68 | 22c. NAME OF CEMETERY OR CREMATORY Greenmount | 22d. LOCATION (City, town, or county) (State) Baltimore Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. | | 24a. REC'D BY REGISTRAR NOV 20 1968 | |
| ADDRESS 4905 York Road Balto. 12, Md. | | 24b. REGISTRAR'S SIGNATURE [Signature] | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in part 1 and part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

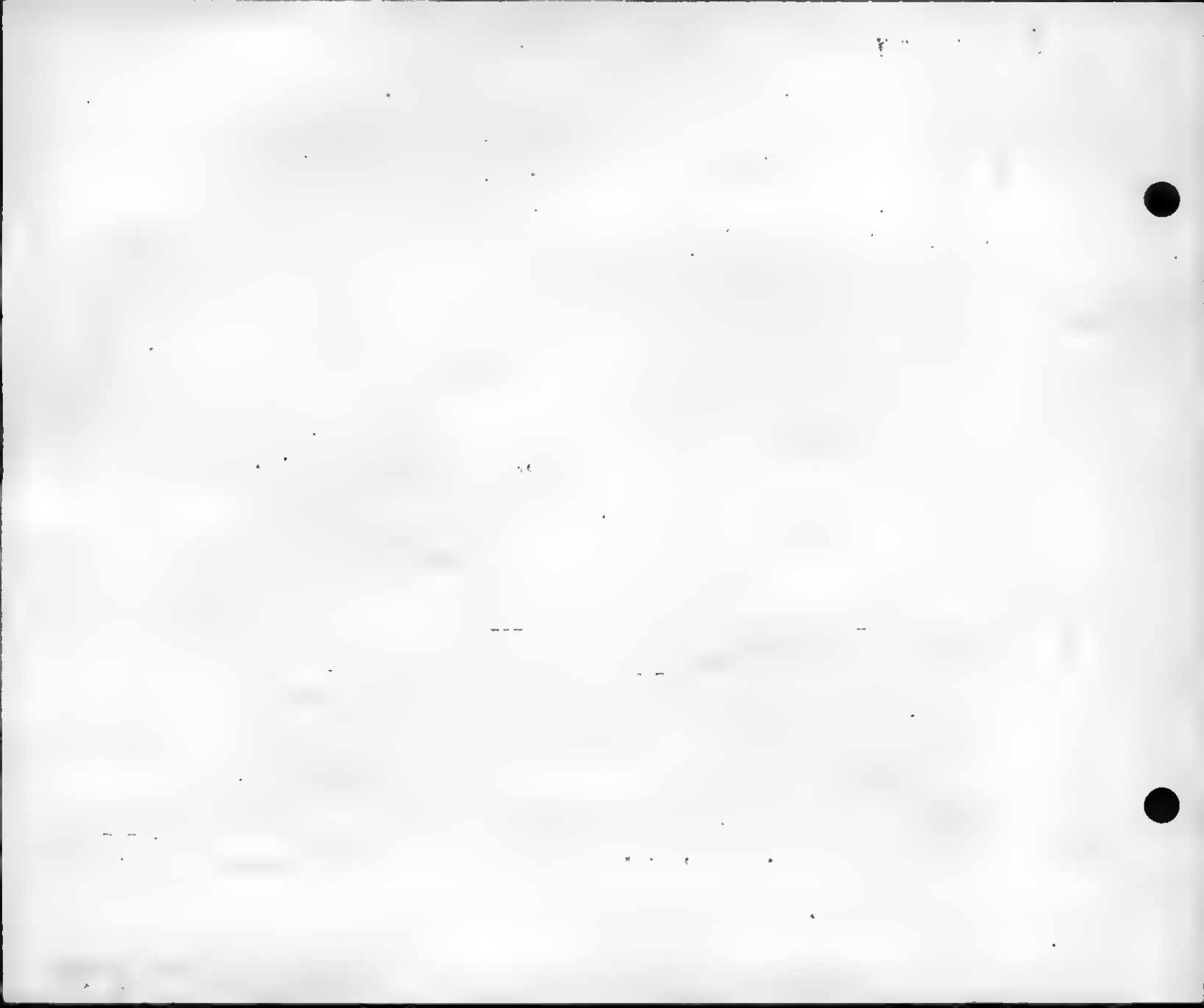
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15572

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15593

| | | | | | | | | | | | |
|--|---------------------|--|--|---|--|--|---|---|------------------------|--|--|
| 1. DECEASED NAME (Type or Print) George | | First George | | Middle | | Last JENKINS, Jr. | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 11 7 1968 | | 2b. HOUR 4 P.M. | |
| 3 SEX Male | 4 RACE Negro | 5 DATE OF BIRTH Aug 26, 1937 | 6 AGE (in years last birthday) 31 YRS | 7 UNDER 1 YEAR MONTHS ? DAYS ? | IF UNDER 24 HRS HOURS ? MIN ? | | 2c. DATE PRONOUNCED DEAD 11 7 1968 | | 2d. HOUR 4 P.M. | | |
| 7a. BIRTHPLACE (State or foreign country) Greenville S.C. | | 7b. CIT. ZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | | Md | |
| 10. CITY OR TOWN OF DEATH Sparrows Point | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Plant Dispensary | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steel Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Making | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 606 Peach Orchard Lane | | | |
| 14. FATHER'S NAME George Jenkins | | First George | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME Annabell Jenkins | | First Annabell Middle Jenkins Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Roseetta Jenkins | | ADDRESS 1528 Edmond Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing injuries with multiple fractures of ribs, pelvis and right femur. 3rd degree burns over chest & Abdomen DUE TO, OR AS A CONSEQUENCE OF (b) Crushing injuries with multiple fractures of ribs, pelvis and right femur. 3rd degree burns over chest & Abdomen DUE TO, OR AS A CONSEQUENCE OF (c) Crushing injuries with multiple fractures of ribs, pelvis and right femur. 3rd degree burns over chest & Abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 712.3 none | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7-12-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? none | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 11-7-68 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pinned by machine at work | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) At work | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Melvin B. Davis | | EXAMINER'S NAME (Type) Melvin B. Davis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 11-7-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov 12/68 | | 23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Park | | 23d. LOCATION (City or Town) Laurel (County) Ind. (State) Ind. | | 24. FUNERAL DIRECTOR Zorah E. Elikson | | ADDRESS 1129 N. Canton St | |
| 25a. REC'D BY REGISTRAR NOV 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

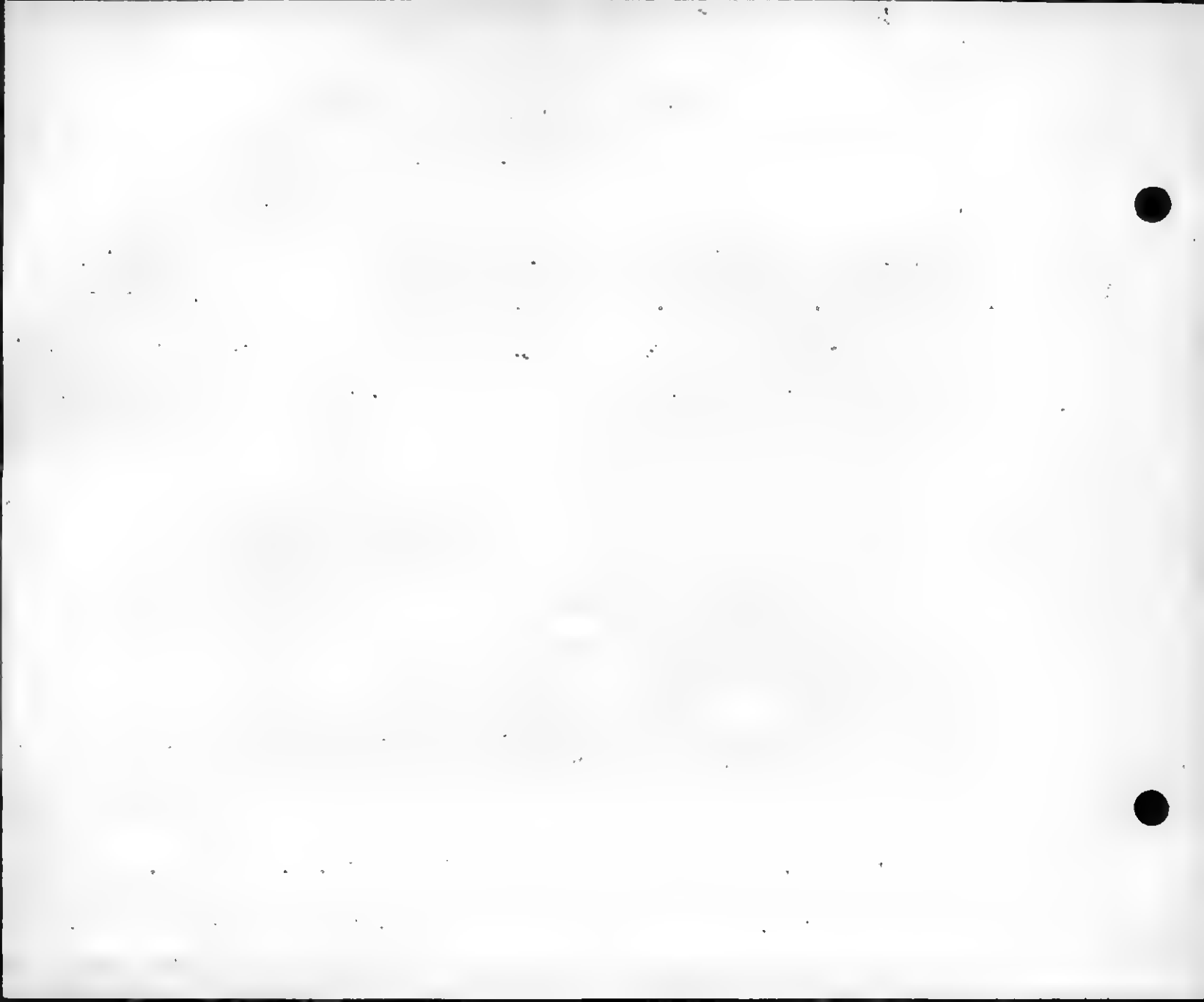
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15574

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15586

| | | | | | | | | |
|---|--------|--|--------------------------|--|--------------------------------|--|-----------------------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| HARRY | | CECIL | JOHNSON | | 11 | 07 | 68 | 5 A M |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| MALE | CAU | | 25-05 | | 63 | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| W. VIRGINIA | | U.S.A. | | | | BALTIMORE Md. | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTO. MD. | | GRTR. BALTO. MED. CENTR. | | HELP | | BLINDS VENETIAN | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| BALTIMORE, MD. | | BALTO. | | BALTIMORE | | | | 106 S. STRICKER ST. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| STANSBERRY | | | JOHNSON | | | LYDIA M. VANWAY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | | | |
| YES | | WW II | | LUCKY H. JOHNSON 106 S. STRICKER ST. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CANCER 1621 DUE TO, OR AS A CONSEQUENCE OF CA LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-04, 19 68, to 11-07, 19 68, that (I) (we) last saw the deceased alive on 10-07, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | |
| M. MOUSSAVI | | | | | | 10-07-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| M. MOUSSAVI | | | | GBMC 6701 N. CHARLES ST. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | NOV. 11, 1968 | | BALTO. NATIONAL CEM. | | BALTIMORE-MARYLAND. | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| WALTERS FUN'L HOME PRATT + STRICKER ST. | | | | DATE NOV 12 1968 | | f Charles Judge | | |

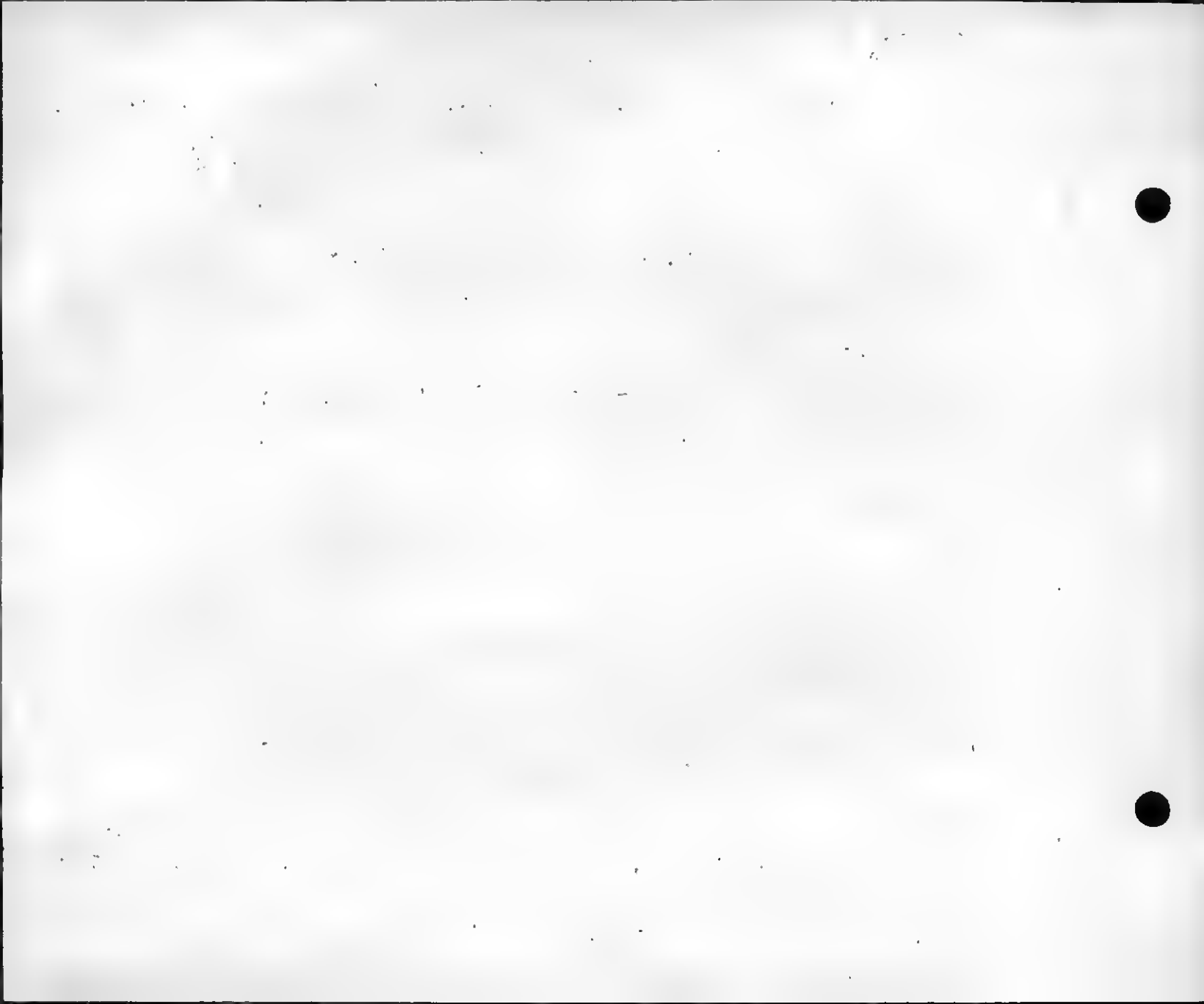


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VR A15 (4)
30M REV 1/68

| <div>15575</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15587</div> | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---------------------------------|--|--|
| 1. DECEASED NAME (Type or print) | | | First Robert | | | Middle Lee | | | Last JOHNSON | | | 2c. DATE OF DEATH Month November Day 7 Year 1968 | | | 2b. HOUR A M 2:46 | | |
| 3 SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 11-10-03 | | | 6. AGE (in years, lost birthday) 54 MONTHS 6 DAYS 14 | | | IF UNDER YEAR MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Armco Steel | | | | | | | | |
| 13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 2609 Hillcrest Avenue | | | | | |
| 14. FATHER'S NAME First Irvin Johnson | | | Middle Last | | | 15. MOTHER'S MAIDEN NAME First Anna Frey | | | Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-07-7773 | | | 17. INFORMANT Wife: Louise Johnson | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> 451.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331.2 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> , 19 <u>68</u> , to <u>11-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-7-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Illiana</u> | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 11-7-68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ines Gilliam, M.D. | | | 22e. ADDRESS 7620 York Road, Towson, Md. 21204 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/11/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | | | 23d. LOCATION (City or Town) (County) (State) Brooklyn Anne A Co. | | | | | | | | |
| 24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR DATE NOV 12 1968 | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | |



**FOR STATE
HEALTH DEPT.**

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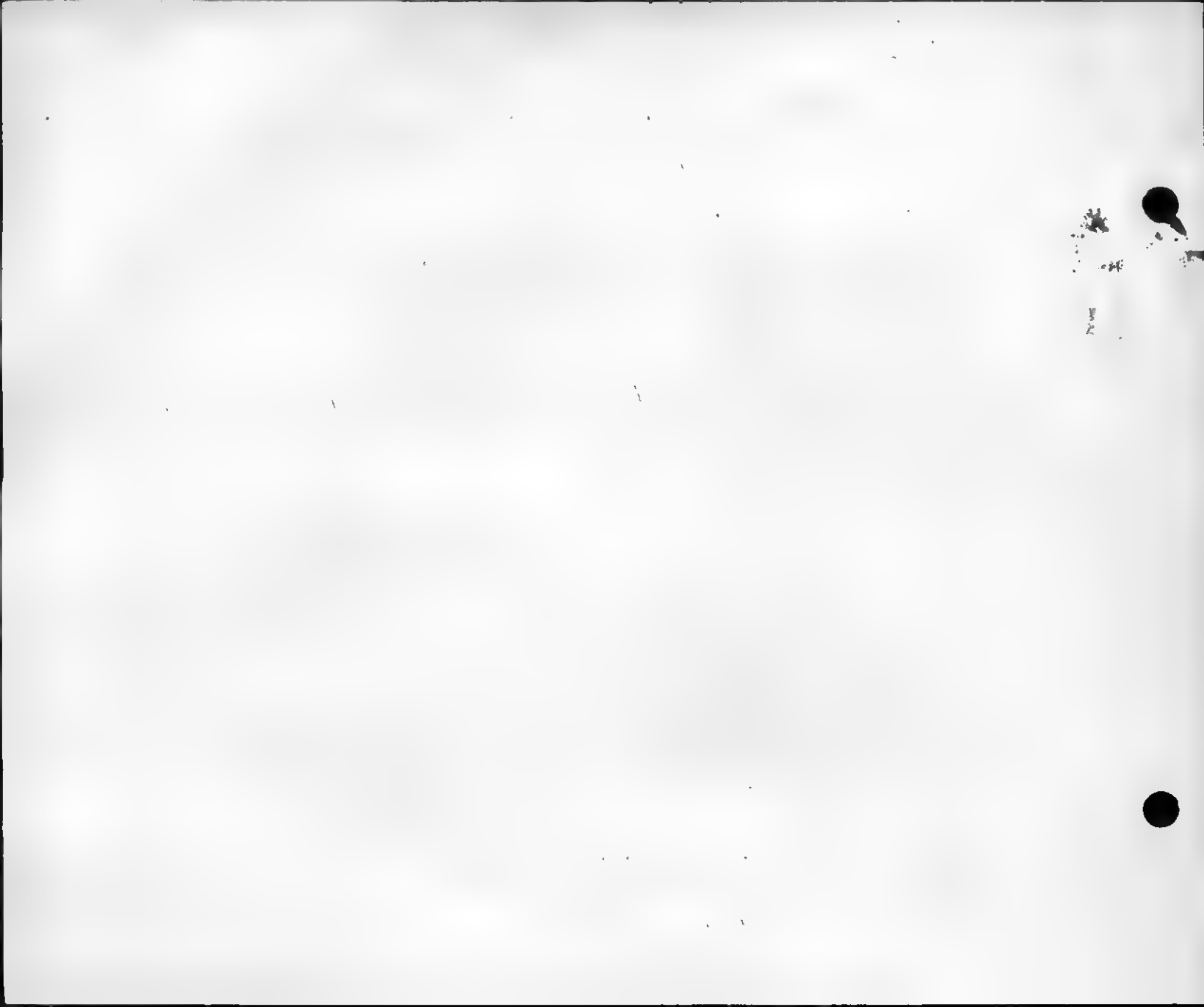
VR A15ME (5)
10M REV. 1/68

15576

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15588

| | | | | | | | |
|--|-----------------|---|--|--|---|---|---|
| 1. DECEASED NAME (Type or Print) First Middle Last JAMES Joseph F. JOYCE | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 11/12/68 19 | | | 2b. HOUR 6:00 A. M. | |
| 3 SEX male | 4 RACE white | 5 DATE OF BIRTH April 3, 1920 | 6 AGE (in years last birthday) 48 YRS. | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year November 12, 1968 | | 2d. HOUR 6:30 A. M. |
| 7a. BIRTHPLACE (State or foreign country) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH Dundalk | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) In front of 7405 School Ave | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bundler | | 12b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution address) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME First Middle Last Michael Joyce | | 15. MOTHER'S MAIDEN NAME First Middle Last Marie Connolly | | 13e. STREET AND NUMBER 2613 Llewellyn Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 203-01-6334 | | 17. INFORMANT E. Irene Joyce-2613 Llewellyn Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Alteration of Liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Noturol causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 11/12/68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Cap Lawm Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR John C. Miller Inc-415 Belair Rd.-21206 | | | | 25a. REC'D BY REG STRAR DATE NOV 18 1968 | | 25b. REG STRAR'S SIGNATURE Charles Judge | |



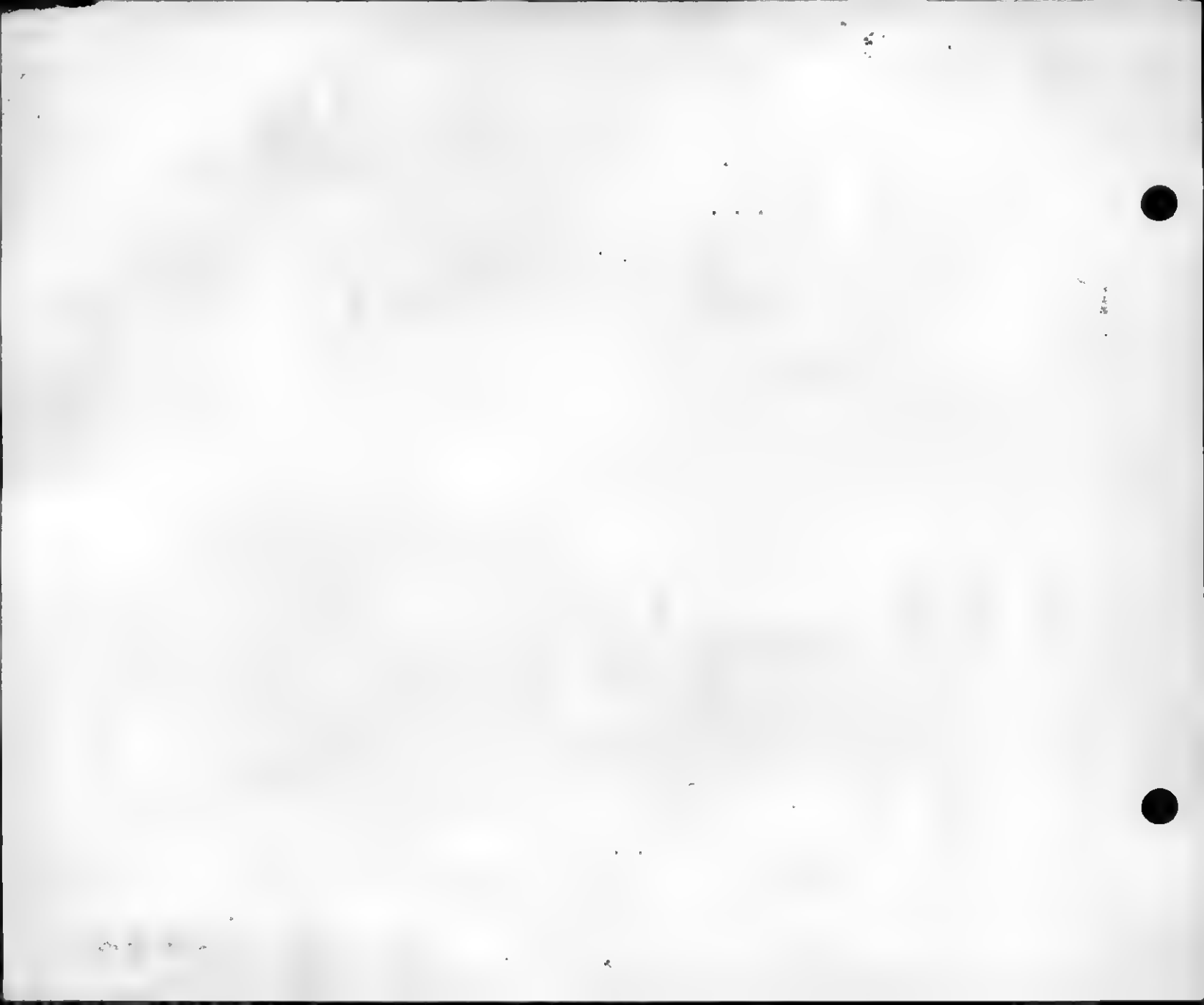
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

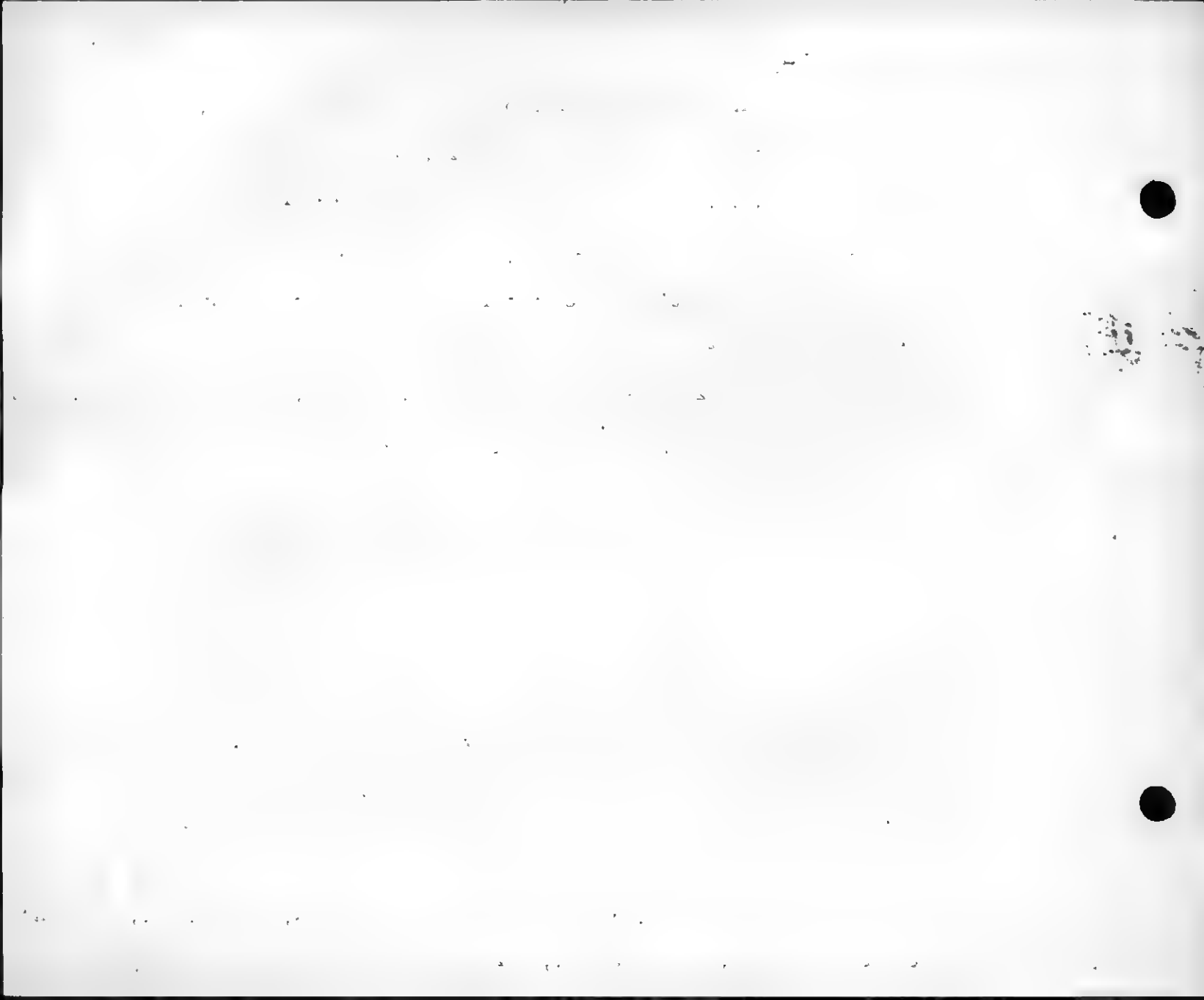
| | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last KATHLEEN HAZEL KALBSKOPF | | | | | | | | | | 2a. DATE KNOWN OF DEATH Month Day Year 11/10 1968 | | 2b. HOUR OF DEATH p. M. 4:30 p. M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH Sept. 28, 1946 | | 6. AGE (In years last birthday) 22 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. None | | 7c. DATE PRONOUNCED DEAD Month Day Year November 10, 1968 | | 7d. HOUR OF DEATH p. M. 6:00 p. M. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 8453 Water Oak Road | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. CITY Baltimore | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 8453 Water Oak Road | | | |
| 14. FATHER'S NAME First Middle Last Ferdinand Kalbskopf | | | 15. MOTHER'S MAIDEN NAME First Middle Last Marian Davidson | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Ferdinand Kalbskopf | | | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2554 Congestive Heart Failure due to Anemia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 295X Mongolism | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 295X | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED 11/11/68 | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 11/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc | | | | | | ADDRESS Baltimore, Maryland | | | | 25a. REC'D BY REGISTRAR NOV 12 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|---|---|-----------------------------------|--|-----------------|
| 15578 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15590 | |
| 1. DECEASED NAME (Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Catherine Elizabeth Kearney | | | | November 13, 1968 | | M | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| Female | Cau. | June 21, 1892 | | 76 YRS. | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Maryland | U.S.A. | | | Baltimore | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cockeysville | Powers Ave. | | Homemaker | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | Baltimore | Cockeysville | | Powers Ave. | | | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Edward Powers | | Catherine Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | 212-24-2486B | | Katherine H. Roberts, 10508 Somona Ave. 21030 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 22, 1962</u> to <u>Nov. 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>M. X. Quinn M.D.</u> DEGREE | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>11-14-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| BURIAL | | 11-16-1968 | | St. Joseph's Cemetery | | Texas, Balto. Co., Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. Cook-Brooks Towson, 1050 York Rd., 21204 | | | | NOV 18 1968 | | <u>[Signature]</u> | |



FOR STATE HEALTH DEPT.

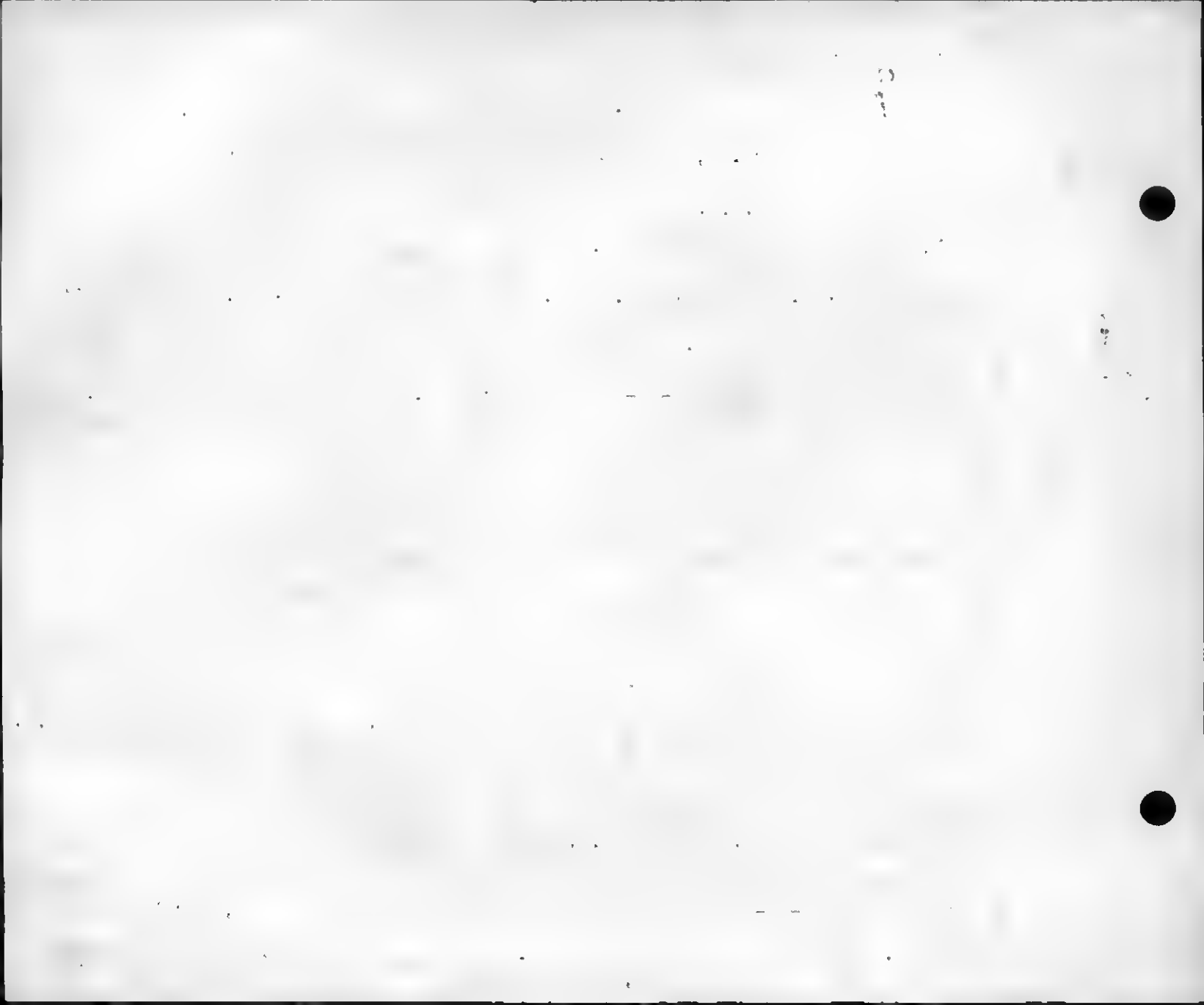
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 307
12/3/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
15579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1350

| | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|
| 1 DECEASED-NAME (Type or Print) FRANCIS | | Middle C. | | Last KEENAN | | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> P <input type="checkbox"/> M | |
| 3 SEX Male | 4. RACE White | 5. DATE OF BIRTH Oct. 3, 1922 | 6 AGE (In years, last birthday) 46 YRS | 7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | 12c. DATE PRONOUNCED DEAD Month Nov. Day 24 , Year 68 | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Male Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balt. | | 13c. CITY OR TOWN Mt. Wilson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First James Middle J. Last Keenan | | 15. MOTHER'S MAIDEN NAME First Agnes Middle F. Last Byrn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | |
| 16b. SOCIAL SECURITY NO. 219-10-4537 | | 17. INFORMANT ADDRESS Vincent I. Keenan 1856 Loch Shiel Rd. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Traumatic Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.7 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. Nov. 19 68 P.M. UNK. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Pedestrian struck by car | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street | | 21f. LOCATION Street or R.F.D. No. Loch Raven Blvd. | | City or Town Balto County M.D. State M.D. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED November 25, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Raymond J. Curran | | ADDRESS 817 Scarlett Dr. Towson, Maryland 21204 | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

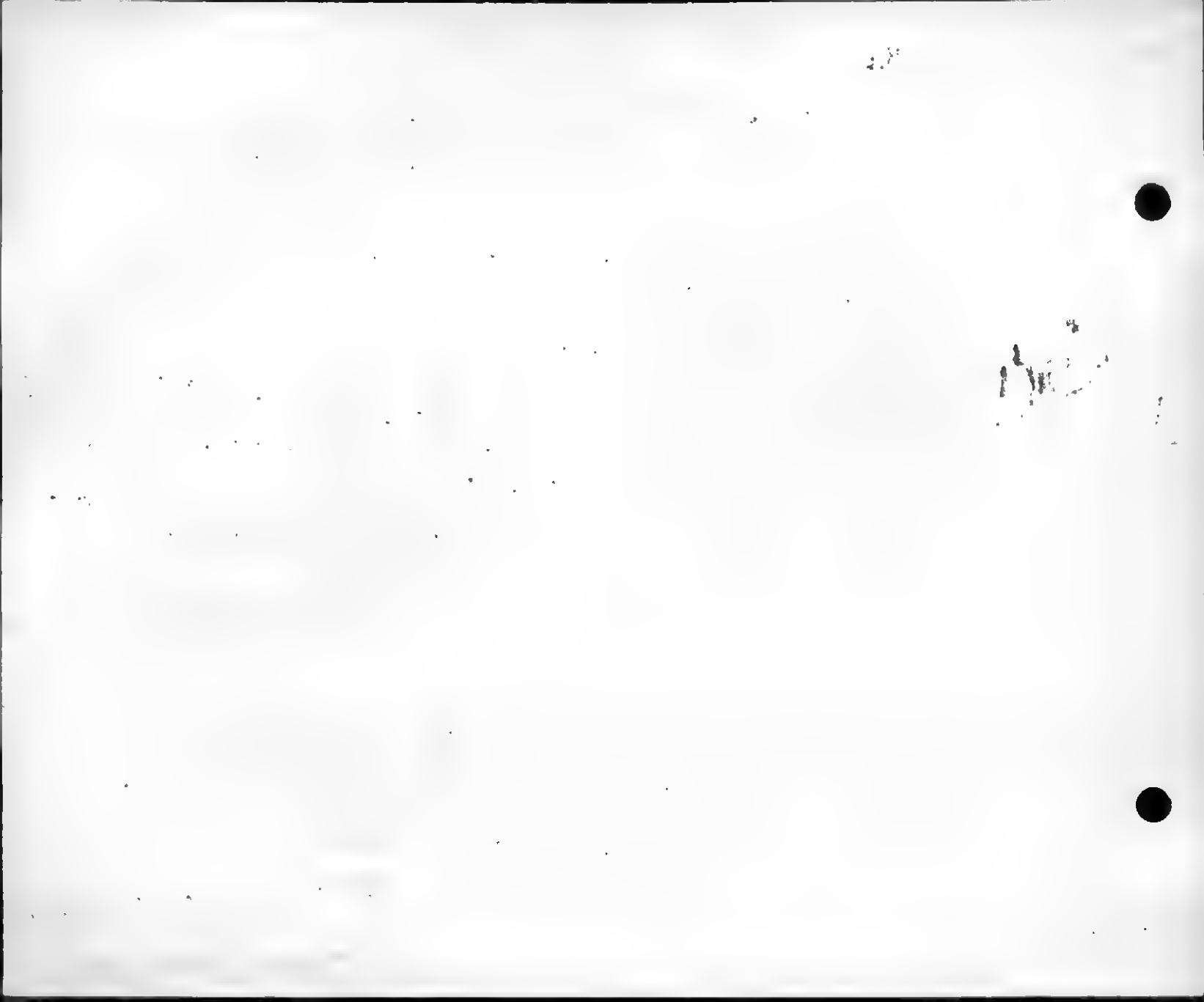
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15580

15580

CERTIFICATE OF DEATH

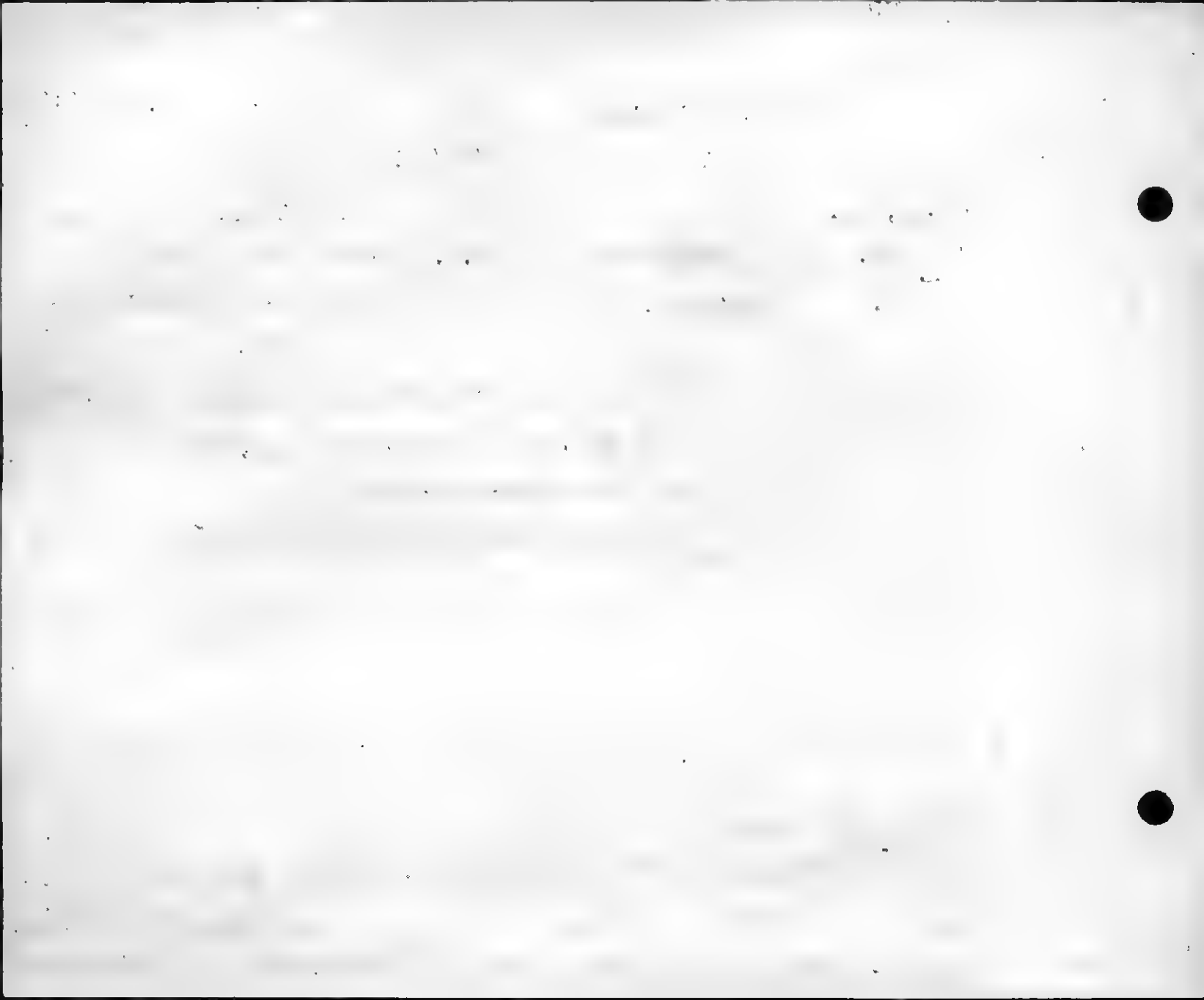
| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last FRANCES ETHEL KELBAUGH | | | 2a. DATE OF DEATH Month Day Year NOV 25 1968 | | | 2b. HOUR 2:45 P.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH AUG 3, 1892 | | 6. AGE (In years last birthday) 76 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTO. Md. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) TOWSON CONV. HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 6004 YORK RD. | | 14. FATHER'S NAME First Middle Last THOMAS KELBAUGH | | 15. MOTHER'S MAIDEN NAME First Middle Last ARIETTA WILHELM | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT Raymond Drechsler, Address 750 PAIRU CUN Ave HUN 1-1112 Mid 21403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardio Renal Vasoconstriction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4th</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> , to <u>Nov 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Charles F. O. Donnell</u> | | | | 22c. DATE SIGNED 11/25/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Charles F. O. Donnell | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt CARMEL Methodist | | 23d. LOCATION (City or Town) (County) (State) BALTO. Co - MD. | |
| 24. FUNERAL DIRECTOR Wm Cook-Brooks Towson | | | | 25a. REC'D BY REGISTRAR DATE NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

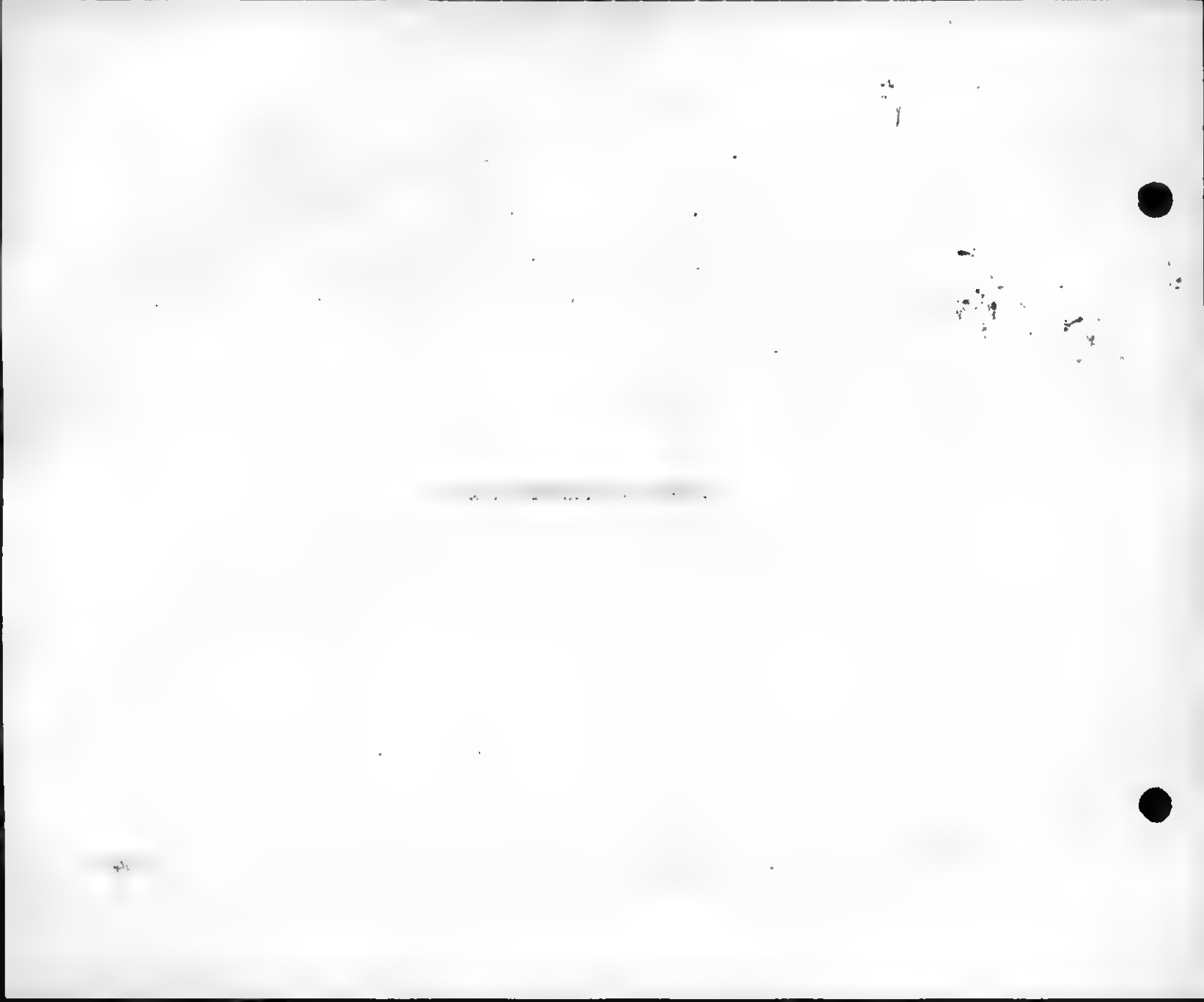
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--------------------------|--|---|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Robert Kellum | | | | | | Month 11 Day 12 Year 68 | | 2:25 P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | |
| Male | | White | | 9/29/1875 | | 93 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Towson, Md. | | USA | | | | Baltimore | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Md. | | Chesapeake Manor N.H. | | | | Machinist Gas & Electric Co. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Baltimore | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1911 Queensway | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| unk. | | | unk. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | | 212-05-3009 | | Robert L. Kellum 1110 Arran Rd. Balto. 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Acute and Chronic Renal Failure | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 2. Bronchopneumonia | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) 3. Cerebral Vascular Accident | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11, 1968, to 11/8, 1968, that (I) (we) last saw the deceased alive on 11/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Jamshid Hamed-Mid | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) JAMSHID HAMED-MID | | | | | | 22e. ADDRESS 204 E/ Joppa Rd. Balto. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| burial | | 11/15/68 | | Western | | Balto., Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Mitchell-Wiedefeld Home 6500 York Rd. #21212 | | | | DATE NOV 19 1968 | | Charles Judge | | | | |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



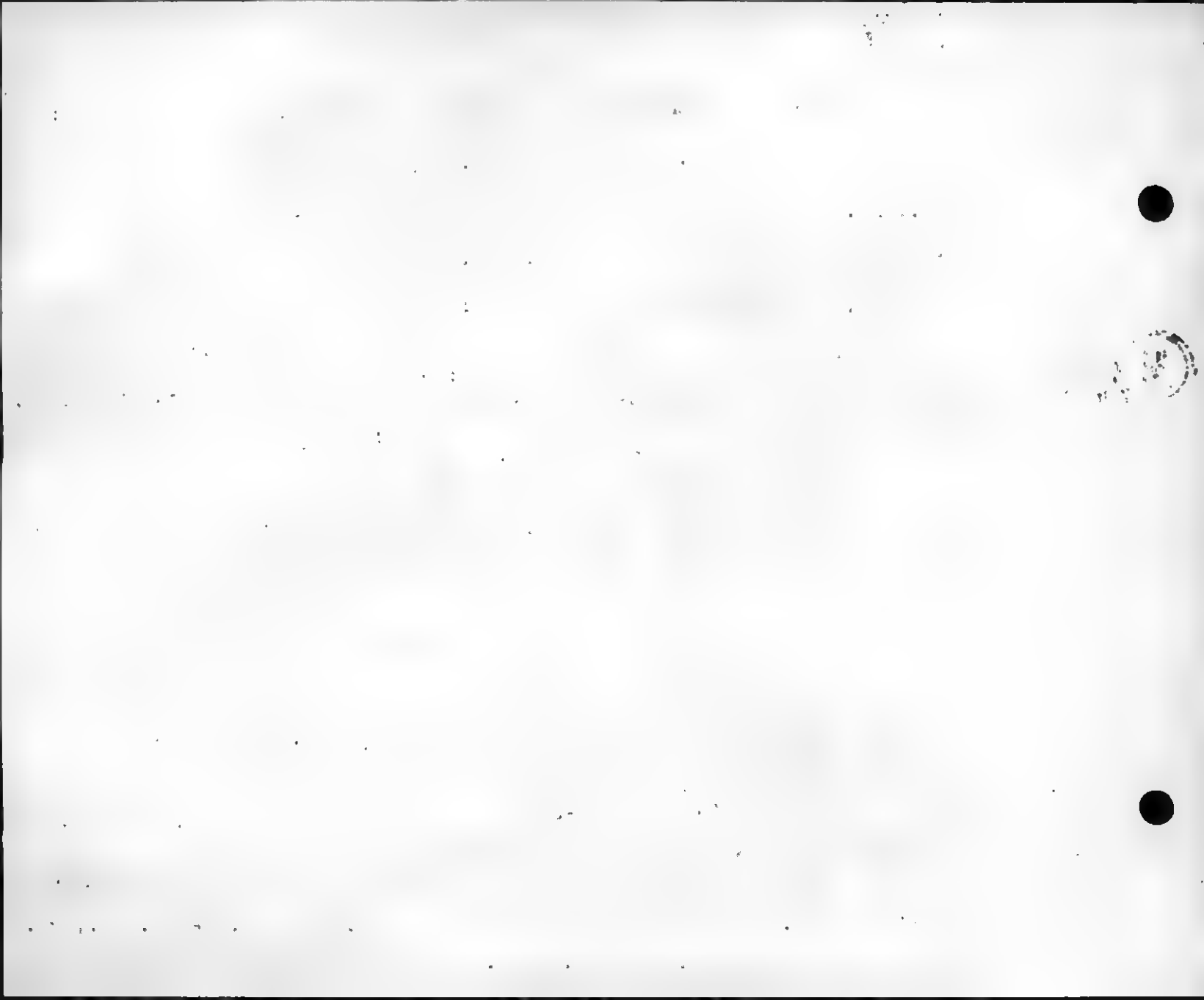
| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| <div style="font-size: 24pt; font-weight: bold; margin-bottom: 5px;">15588</div> <div style="font-size: 12pt; font-weight: bold;">DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div style="font-size: 18pt; font-weight: bold;">CERTIFICATE OF DEATH</div> | | <div style="font-size: 12pt;">15588</div> | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | | 2a DATE OF DEATH | | | | 2b HOUR | |
| First | | Middle | | Last | | Month | | Day | |
| Matilda | | Mary | | KELLY | | 11 | | 16 | |
| Year | | 1968 | | 4 | | A | | M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 24 HRS. | |
| Female | | White | | 2-28-1894 | | 74 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore, | | Md | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | ST. JOSEPH HOSPITAL | | Homemaker | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INS OF CITY UM TSP | | 13e STREET AND NUMBER | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1421 Walker Ave. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| First | | Middle | | Last | | First | | Middle | |
| Ferdinand | | Russey | | | | unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| | | 219-30-4320 216-32-5779D | | Mildred F. Rohm, dght. above | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism massive | | | | | | | | | |
| 4 - DUE TO, OR AS A CONSEQUENCE OF (b) HEART DISEASE | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 463-X | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Generalized peritonitis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION | | Street or R.F.D. No | | City or Town | |
| | | | | | | | | County | |
| | | | | | | | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 11-6-1968, to 11-16-1968, that (X) (we) last saw the deceased alive on 11-16-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | 22c DATE SIGNED | | | | | |
| Christine Feliciano, M.D. | | | | 11-16-68 | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS | | | | | |
| Christine Feliciano, M.D. | | | | 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) (State) | |
| Burial | | 11/20/68 | | Bohemian National Cem | | Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Schlunke Funeral Home, Inc. 3331 Brehms Lane | | | | NOV 21 1968 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar and 2 directors, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First ADDIE | | Middle JOHANNES | | Last KERNS | | 2a. DATE OF DEATH Month November Day 14 Year 1968 | | 2b. HOUR P. 8:40 M |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Nov. 21, 1875 | | 6 AGE (In years last birthday) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | |
| 10 CITY OR TOWN OF DEATH Lutherville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) College Manor, Inc. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c CITY OR TOWN Owings Mills | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER "Chattolance Hill" | | |
| 14. FATHER'S NAME First Edward | | Middle Johannes | | Last | | 15 MOTHER'S MAIDEN NAME First Maria | | Middle Adeline | | Last Williams |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 220-54-2936 | | 17. INFORMANT : son- J. Seeger Kerns | | Address Owings Mills, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial failure | | | | | | | | | | 6 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | 20 years |
| DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis | | | | | | | | | | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 16 , 19 50 , to Mar 14 , 19 68 , that (I) (we) last saw the deceased alive on Mar 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE Edwin P. Williams M.D. | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED Mar 15-68 |
| 22d. PHYSICIAN'S NAME (Type) Edwin P. Williams | | 22e. ADDRESS Owings Mills, Md. | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR STEWART & MOWEN CO. | | ADDRESS 108 W. North Av. Balto. 1 | | 25a REC'D BY REGISTRAR NOV 18 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (M)
30M REV 7-68

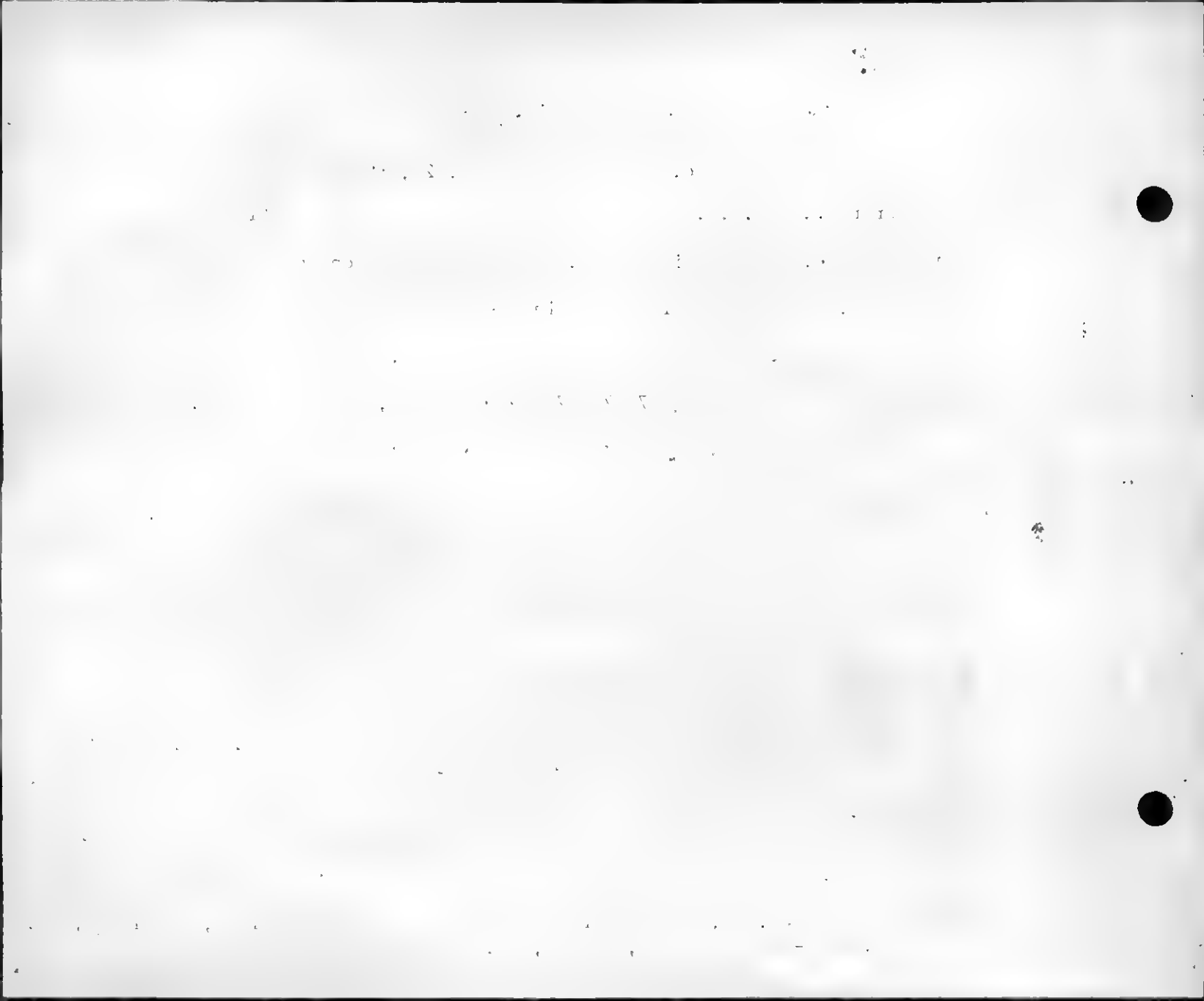
15584

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15586

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print) EMBERT A. Keys | | First Middle Last | | 2a DATE OF DEATH Month 11 Day 26 Year 1968 | | 2b HOUR 9 1/2 AM | |
| 3 SEX Male | | 4 RACE Cauc. | | 5 DATE OF BIRTH Mar. 26, 1893 | | 6 AGE (In years last birthday) 85 YRS. | |
| 7a BIRTHPLACE (State or foreign country) Warren Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md. | |
| 10 CITY OR TOWN OF DEATH White Hall Md. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Weisberg Rd. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Watchman | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b COUNTY Baltimore | | 13c CITY OR TOWN White Hall | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME Lloyd S. Keys | | First Middle Last | | 15 MOTHER'S MAIDEN NAME Eliza M. Bull | | First Middle Last | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No | | 16b SOCIAL SECURITY NO. 717 07 6875 | | 17 INFORMANT Rodger Keys, White Hall, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C. A. C. V. disease 412.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/25, 1968 , to 11/26, 1968 , that (I) (we) last saw the deceased alive on 11/25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE A.M. FRANCE | | | | | | 22c. DATE SIGNED 11/26/68 | |
| 22d. PHYSICIAN'S NAME (Type) A.M. FRANCE | | | | | | 22e. ADDRESS PARKTON, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Nov. 30, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Poplar | | 23d. LOCATION (City or Town) (County) (State) Cockeysville, Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Cook-Brooks Towson, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | |

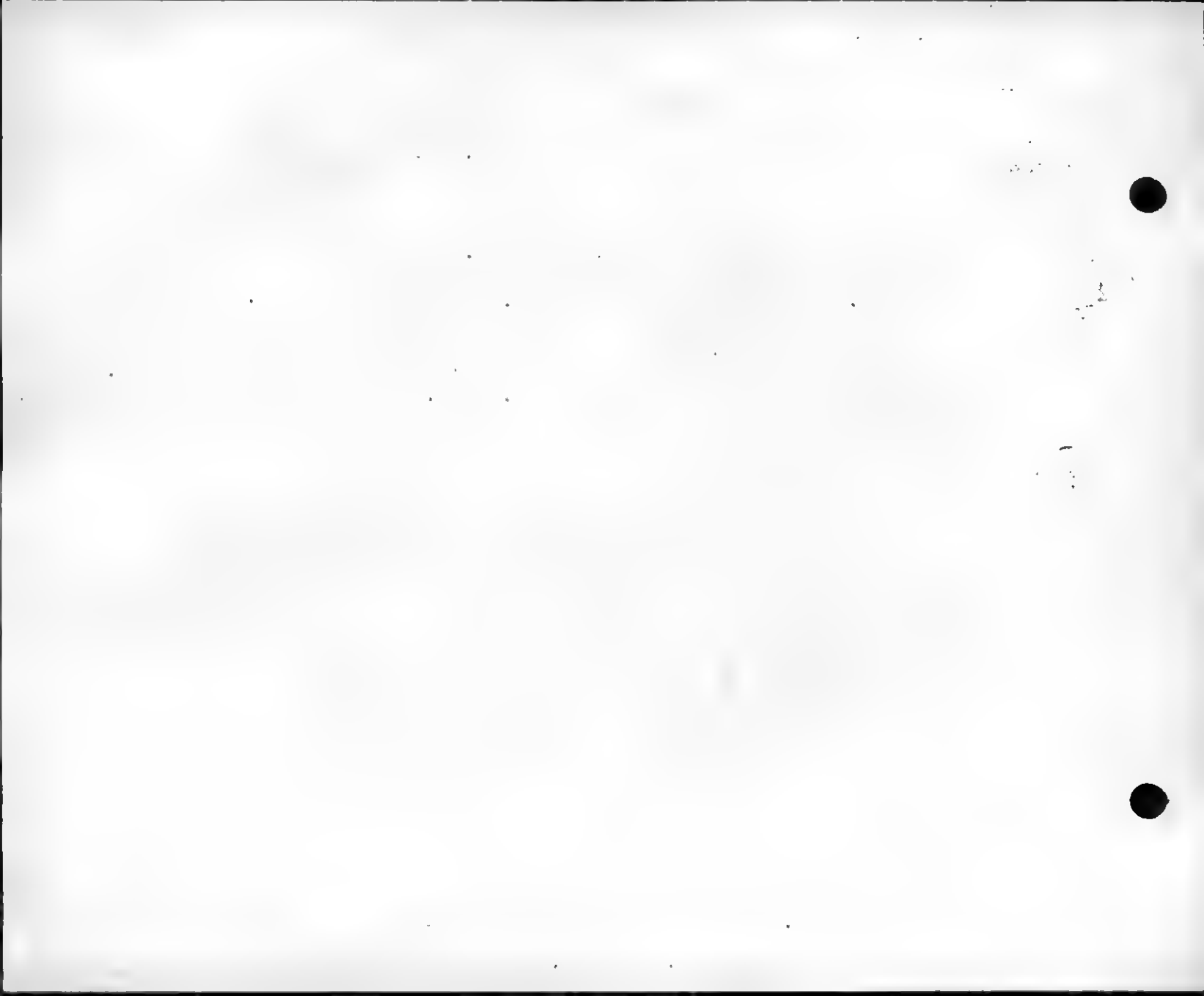


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | |
|---|--|---|-------------------------|--|--|---|------------------|---|
| 1 DECEASED NAME (Type or print) | | First Helen | Middle Boehme | Last King | 2a DATE OF DEATH Nov Month 15 Day 1968 Year | | 2b. HOUR 3 AM | |
| 3. SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Apr. 30, 1876 | | 6 AGE (In years at birthday) 92 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10 CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson N. H. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Balto. | | 13c CITY OR TOWN Balto. City | | 13d INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 3333 N. Charles St. |
| 14 FATHER'S NAME First Middle Last Augustus Boehme | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Mary Josephine Davis | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT : Daughter- Mrs. Geo. W. Wagner, 100 W. Cold Spring Lane, | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Sanguine st. lac. 4444 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Thrombosis of femoral artery DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, generalized PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 wks. 10 yrs. |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from June 1962 to Nov 15, 1968, that (I) (was) last saw the deceased alive on 11/12/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE Dr. Freeman DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/> | | | | | | 22c DATE SIGNED 11/15/68 | | |
| 22d PHYSICIAN'S NAME (Type) N R FREEMAN JR | | 22e ADDRESS 111 N. 29th St. | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Nov. 16/1968 | | 23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | |
| 24 FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Balto. Md. | | | | 25a REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | | |

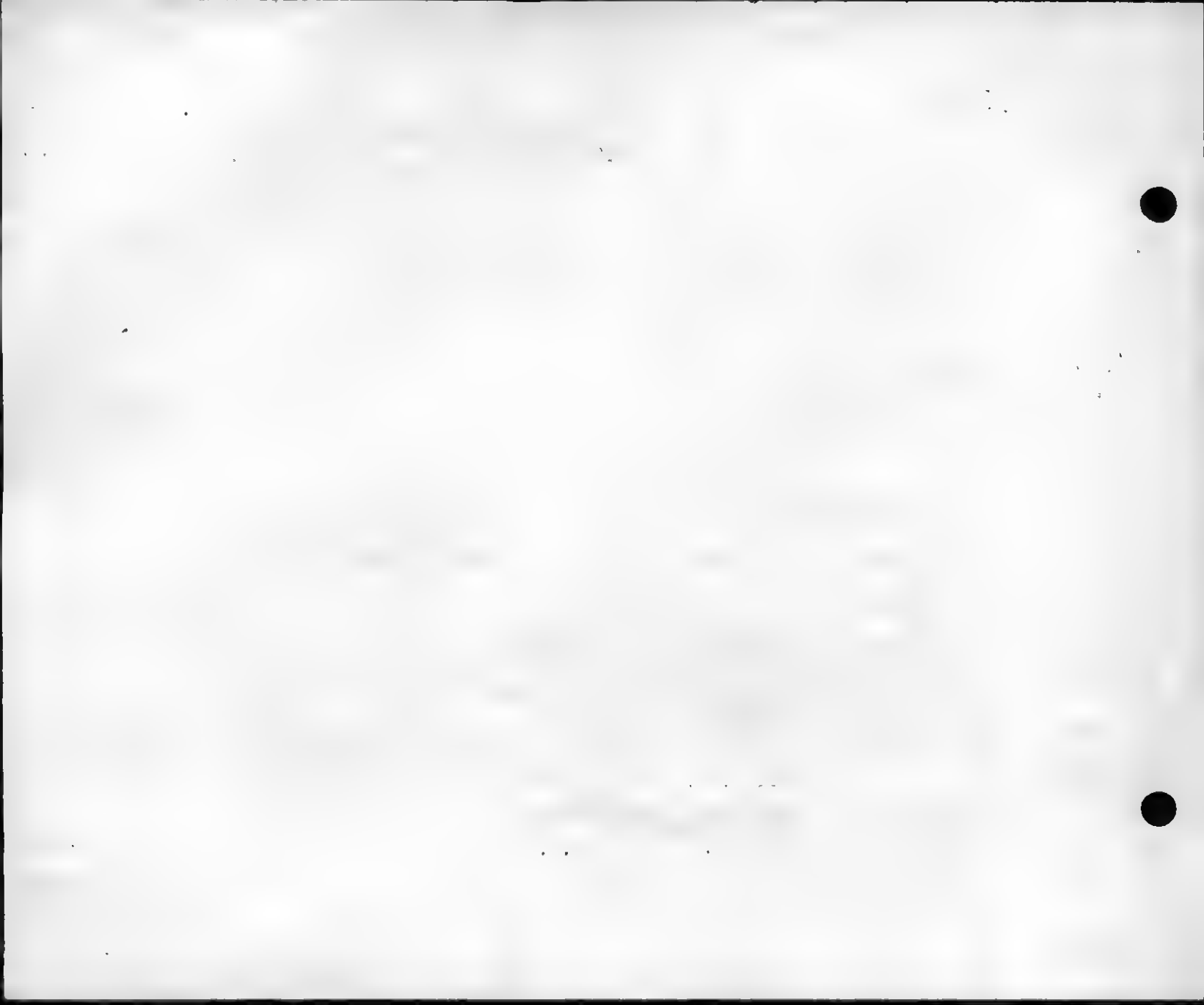


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Complete Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type in full) MILTON | | First | | Middle | | Last KIRK | | 2a. DATE KNOWN OF DEATH Month Nov. Day 19, Year 1968 | | 2b. HOUR 12:45 | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 12-31-1915 | | 6 AGE (in years last birthday) 52 YRS. | | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore | | 2c. DATE PRONOUNCED DEAD Month Nov. Day 19, Year 1968 | | 2d. HOUR 12:45 | |
| 10. CITY OR TOWN OF DEATH Essex | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2915 Eastern Ave. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Essex | | 3d. INSIDE CITY, LA 157 YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2915 Eastern Avenue | | | |
| 14. FATHER'S NAME First Roscoe Middle W. Last KIRK | | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Franklin Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO 577-14-1167 | | 17. INFORMANT ADDRESS Mrs. Lois Miller - 2106 St Paul St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 442 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day Year HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ | | State _____ | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED November 19, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | | 23d. LOCATION (City or Town) (County) (State) Glen Burnie Md. | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. FUNERAL DIRECTOR Wm. J. Trachner & Son Baltimore Md. | | | | | | | | | | | |



15587

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15589
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) SIMON | | First Middle Last KOHLNSTEIN | | 2a. DATE OF DEATH Month November Day 9 Year 1968 | | 2b. HOUR 9 P.M. | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH November 26, 1907 | | 6. AGE (In years lost birthday) 60 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7218 Oak Haven Circle | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Superintendent | | 12b. KIND OF BUSINESS OR INDUSTRY Warehouse | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY (Y.N.T.S.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 7218 Oak Haven Circle | | 14. FATHER'S NAME First Middle Last Louis Kohlenstein | | 15. MOTHER'S MAIDEN NAME First Middle Last Hannah ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Minnie Kohlenstein | | Address Circle 7218 Oak Haven Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma lungs & metastasis 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF lost. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mths | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.) none | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/12, 1965 , to 11/9, 1965 , that (I) (we) last saw the deceased alive on 11/9, 1965 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Maurice Feldman MD | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. PHYS. | | 22c. DATE SIGNED 11/10/65 | |
| 22d. PHYSICIAN'S NAME (Type) Maurice Feldman Jr. | | | | 22e. ADDRESS 6610 Cross Country Blvd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 11, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Oheb Shalom O'Donnell St. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Rd. | | | | 25a. REC'D BY REGISTRAR DATE NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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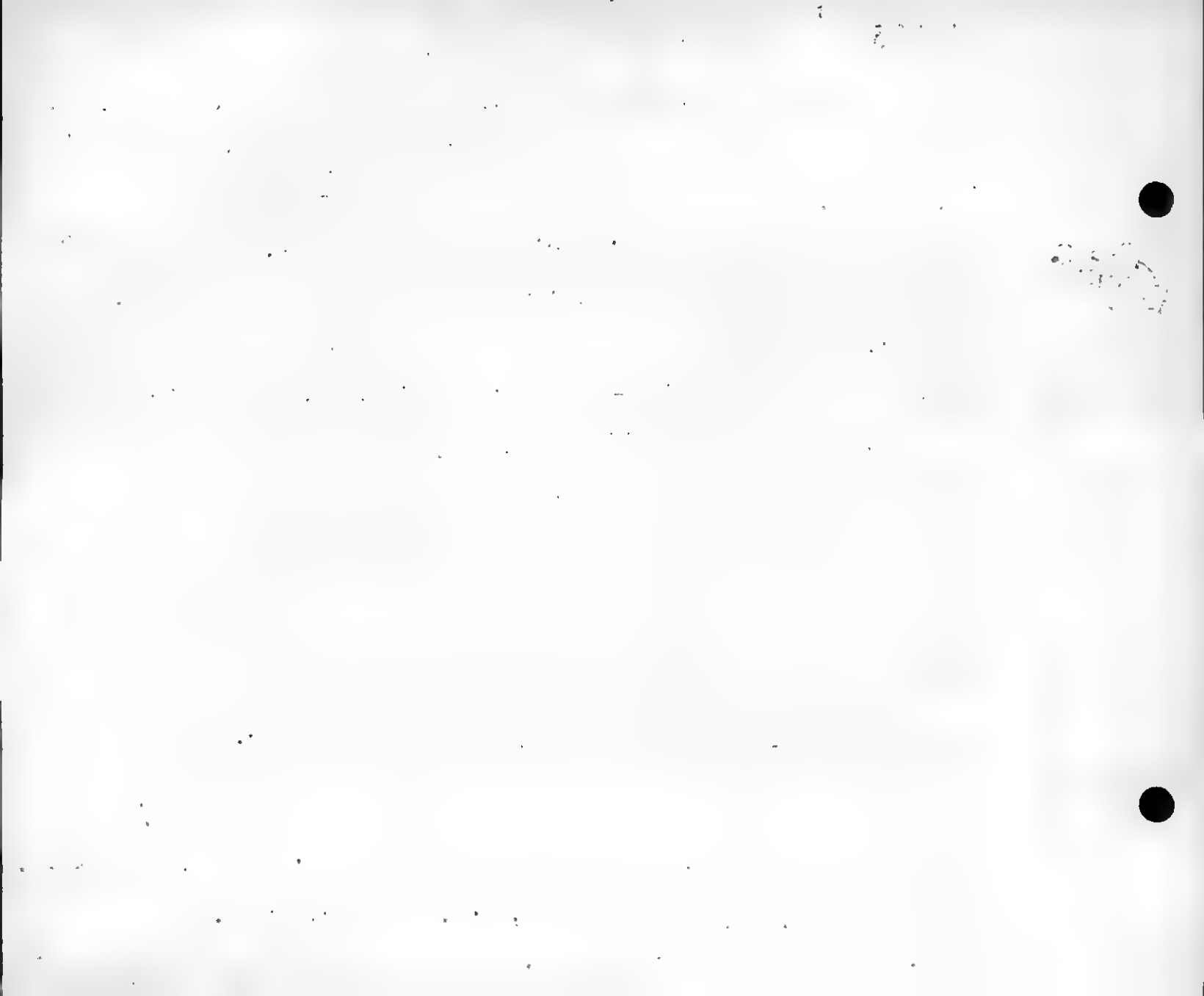
VR A14 (4) 68
30M REV.

15588

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15600

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last Anna Gertrude Korff | | | 2a. DATE OF DEATH Month 11 Day 24 Year 68 | | 2b. HOUR 3:30 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 3/18/86 | | 6. AGE (In years lost birthday) 82 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH Rural Baltimore | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Augsburg Home 6811 Campfield Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Beautician | 12b. KIND OF BUSINESS OR INDUSTRY Beauty Shop | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Balto | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 520 Lyndhurst St. |
| 14. FATHER'S NAME First Middle Last Ferdinand Korff | | | 15. MOTHER'S MAIDEN NAME First Middle Last Anna Reich | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO 220-30-1664A | 17. INFORMANT Address T.W. Katenkamp 9128 Bengal Rd. Randalls | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Psychosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4.2 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital), attended the deceased from <u>March 1967</u> to <u>Nov. 24, 1968</u> , that (I) <u>last</u> saw the deceased alive on <u>Nov. 22, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Earl L. Chambers</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11/25/68 | |
| 22d. PHYSICIAN'S NAME (Type) Earl Chambers | | 22e. ADDRESS Wynwood Towers Cold Spring La. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE Nov. 27, 68 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Pk, Cem. | | 23d. LOCATION (City or Town) (County) (State) Balto Md. | |
| 24. FUNERAL DIRECTOR P.A. Heemann 6067 Harford RD. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



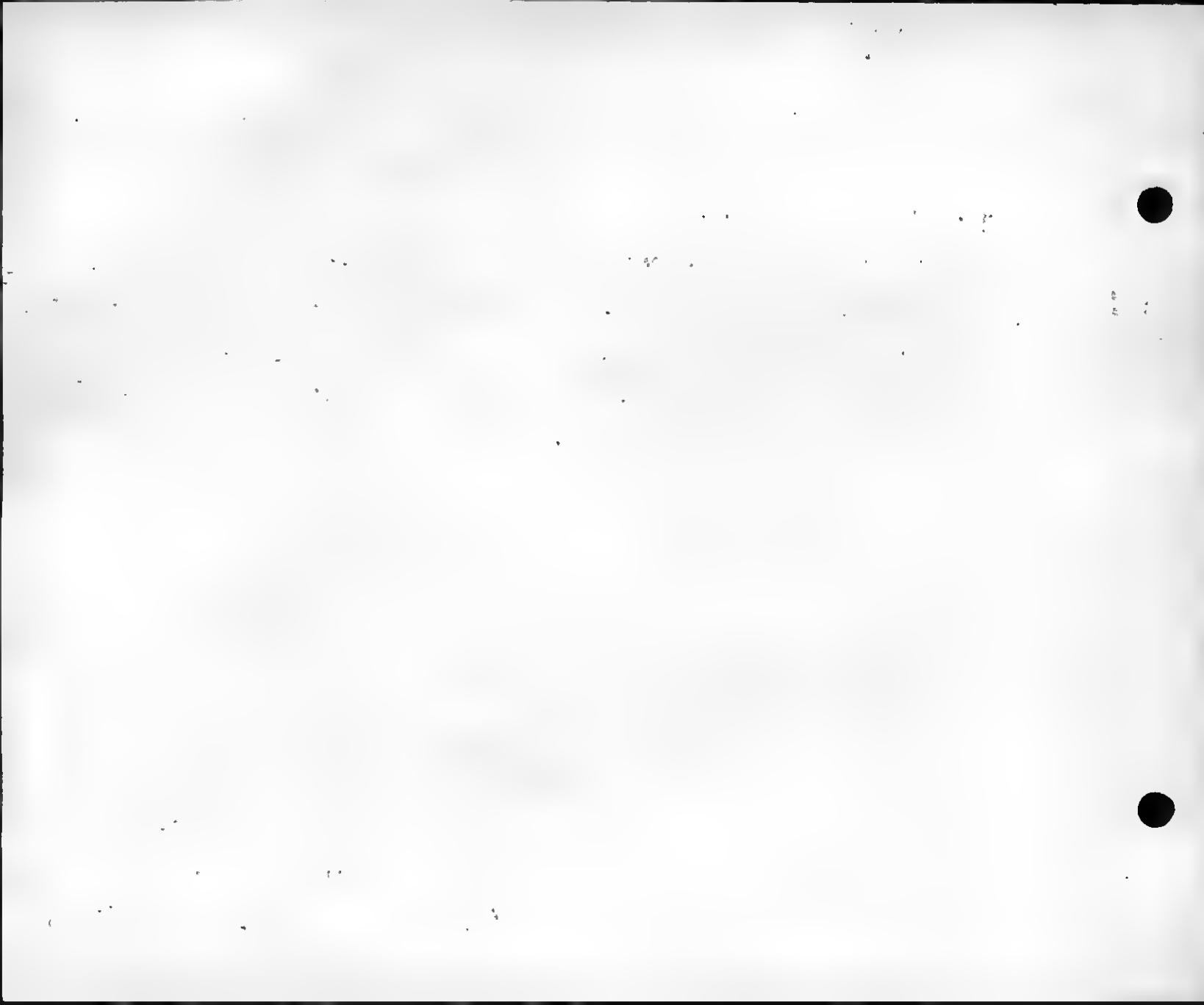
15589

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) Philip | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year November 17 68 | | | 2b. HOUR 7:30 M | | |
| 3 SEX Male | | | 4 RACE White | | | 5. DATE OF BIRTH 4-12-1988 | | | 6. AGE (In years last birthday) 80 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAPER HANGER | | | 12b. KIND OF BUSINESS OR INDUSTRY Homes | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN PARKVILLE | | | 13d. IN CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER 2910 Edgewood Ave., 21234 | | | 14. FATHER'S NAME First Middle Last IGNATIUS Kueberth | | | 15. MOTHER'S MAIDEN NAME First Middle Last Anna Durkin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO 218-52-0844 | | | 17. INFORMANT Address Philip A Kueberth Sand | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Episode Probably Hemorrhage | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 301X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17/1968 to 11/17/1968 , that (I) (we) lost saw the deceased alive on 11/17/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Camilo Z. Tomboc | | | | | | | | | 22c. DATE SIGNED 11-17-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Camilo Z. Tomboc | | | | | | | | | 22e. ADDRESS 7620 York Rd., Towson Md. 21204 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 11/21/1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md | | |
| 24. FUNERAL DIRECTOR CHAR. T. FRANKSON 8802 HANCOCK RD | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 19 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 141
45M 169

15590

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15602

| | | | | | | | | | | | |
|---|--|--|--------|---|----------------------------|---|-------|------------------------|----------|---|----|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month | | Day | Year | 2b. HOUR | | a. |
| MARIANNE | | | | KUTRIK | NOVEMBER | | 9 | 1968 | 11:25 | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| FEMALE | | WHITE | | SEPT. 30, 1921 | | 47 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| BALTO, MD. | | U.S.A. | | | | BALTIMORE | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| TOWSON 4 | | ST. JOSEPH HOSPITAL | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | 13f. BOX | |
| MARYLAND | | | | COCKEYSVILLE | | | | PERRY HALL #28 | | Box 301 A HORNAGO AVE. | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| Hipolit | | | | Rasinski | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 212-16-9558 | | William Kutrik | | Box 301A Hornago Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRAIN TUMOR, MALIGNANT ASTROCYTOMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10-31-</u> , 19 <u>68</u> , to <u>11-9-</u> , 19 <u>68</u> , that (2) (we) last saw the deceased alive on <u>November 9,</u> 19 <u>68</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| <u>Lucas Vidhyaphum</u> | | November 9, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Lucas Vidhyaphum, M.D. | | 7620 YORK ROAD, TOWSON 4, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 11-13-1968 | | Holy Rosary Cemetery | | Baltimore | | | | Md. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>Kassiah Zant/ Home</u> | | <u>7401 Belair Rd</u> | | DATE <u>NOV 13 1968</u> | | <u>Charles Judge</u> | | | | | |

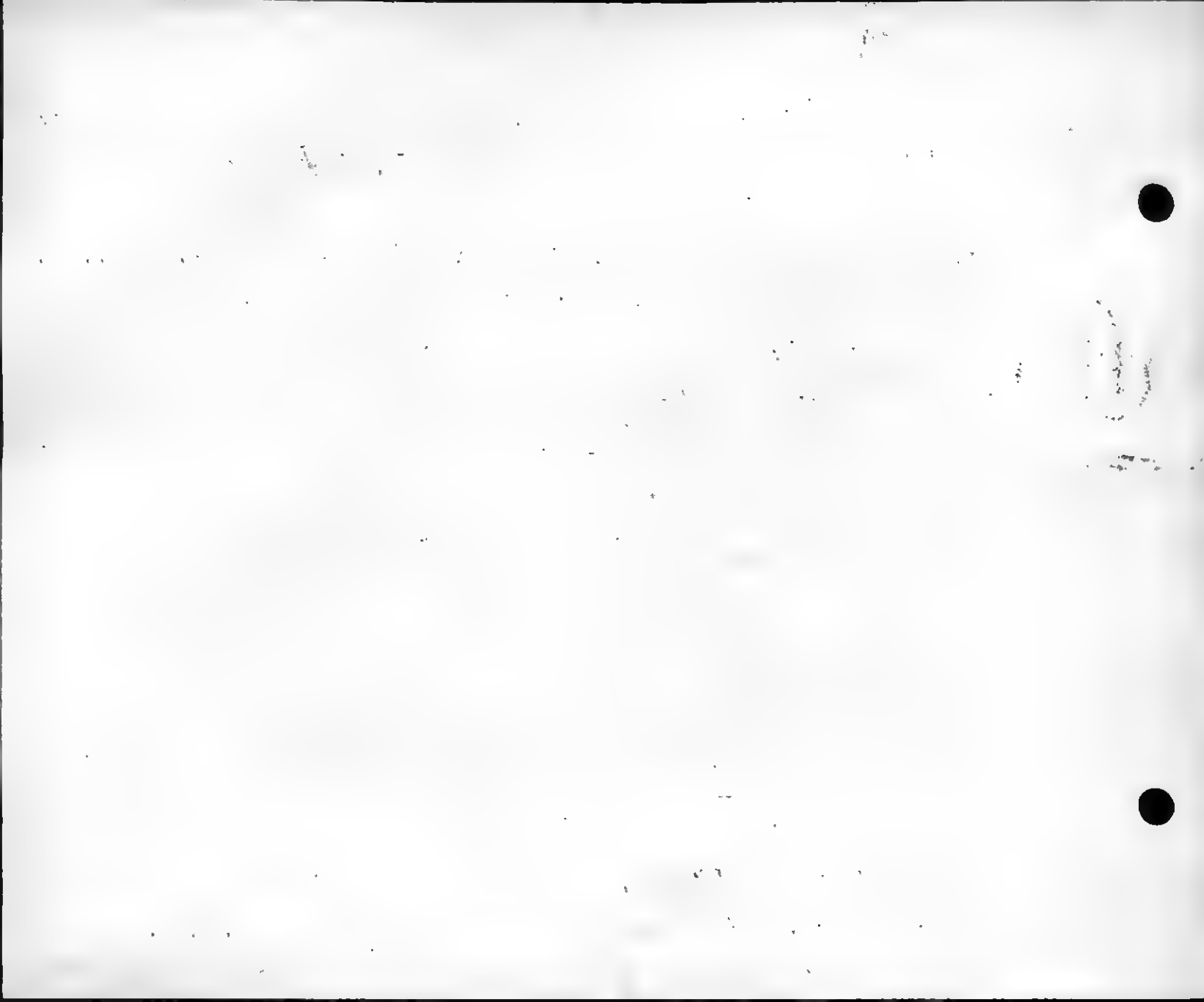


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 15592 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15600 | | | | | | | | | |
|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) ^{1st} <u>William</u> ^{Middle} <u>Armour</u> ^{Last} <u>Kyle</u> | | | | | | | | | | 2a. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1968</u> | | | | | | | | | | 2b. HOUR <u>10:30</u> AM | | | | | | | | | |
| 3. SEX <u>Male</u> | | | 4. RACE <u>W</u> | | | 5. DATE OF BIRTH <u>March 24, 1918</u> | | | 6. AGE (In years lost birthday) <u>57</u> YRS | | | IF UNDER 1 YEAR MONTHS <u>5</u> DAYS <u>10</u> HOURS <u>30</u> MIN | | | IF UNDER 24 HRS. MONTHS <u>5</u> DAYS <u>10</u> HOURS <u>30</u> MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <u>Baltimore</u> | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baldwin</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Baldwin Mill Rd.</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Stripper-carton Co.</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u>148. Co.</u> | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | | 13b. COUNTY <u>Baltimore</u> | | | 13c. CITY OR TOWN <u>Baldwin</u> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER <u>Baldwin Mill Road</u> | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First <u>Lee</u> Middle <u>Jackson</u> Last <u>Kyle</u> | | | | | 15. MOTHER'S MAIDEN NAME First <u>Katie</u> Middle <u>Cullum</u> Last <u></u> | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) <u>WWII</u> | | | 16b. SOCIAL SECURITY NO <u>214-14-7169</u> | | | 17. INFORMANT <u>Family Records</u> Address <u></u> | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | | | | | | | | | | | | | | <u>Immediate</u> | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Generalized Seizure</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>suspected brain tumor</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>420</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. <u>11</u> Month <u>Nov</u> Day <u>1</u> Year <u>1968</u> P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u> | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>68</u> , to <u>Nov.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>William A. Tyson M.D.</u> | | | | | | | | | | DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED <u>11-9-68</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>William A. Tyson</u> | | | | | | | | | | 22e. ADDRESS <u>Kingsville Md.</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>Nov. 12, 1968</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Fork, Balto. Co., Maryland</u> | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | | | | | | | | | ADDRESS <u></u> | | | | | 25a. REC'D BY REGISTRAR <u>NOV 14 1968</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |



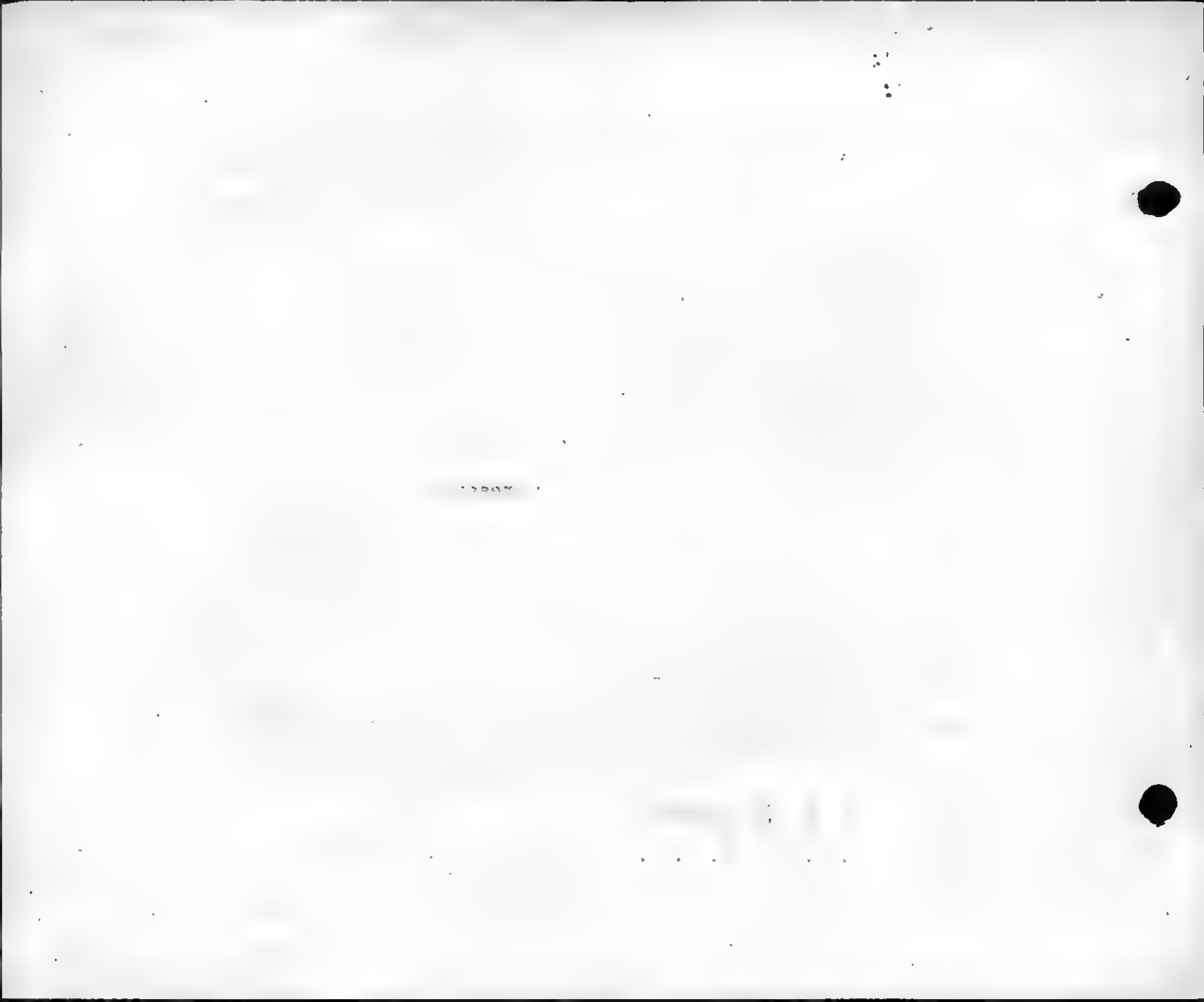
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

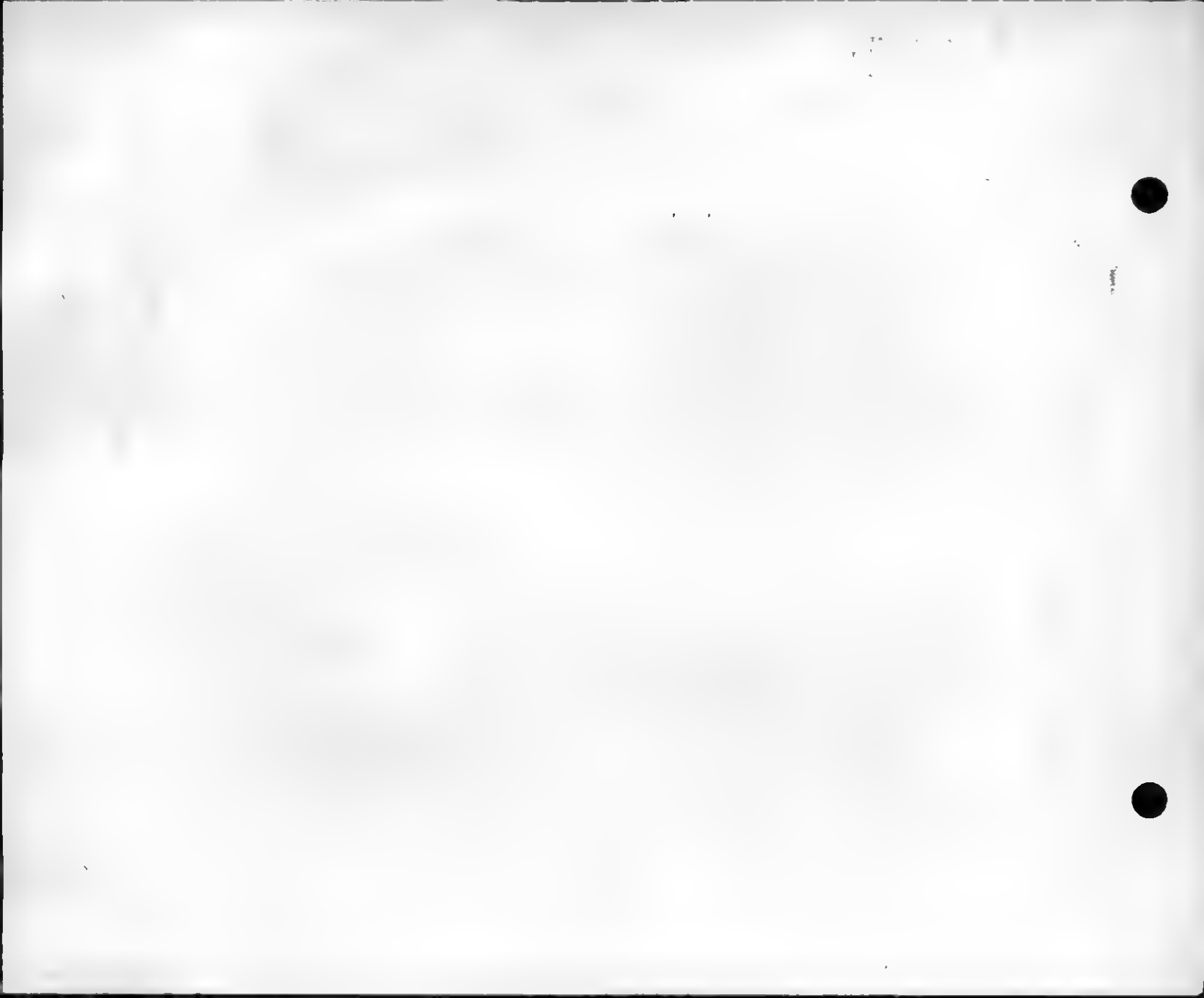
| 15592 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 15604 | |
|--|--------|-----------------|---|--------------------------------|--|---|--|-------------------------|---|--|-----------|-------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | | | |
| Jackson | | | G.F. | | | Lambert | | | 3:40 P.M. | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| Male | Cau. | 10/23/05 | 63 YRS | | | | | 11 26 1968 | | | 3:40 P.M. | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | |
| Md. | | | U.S.A. | | | | | | Baltimore Co. Md. | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Hampstead | | | R. D. 2 | | | Painter | | | Self-employed | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY (M 157) | | | | |
| Md. | | | Baltimore | | | Hampstead | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | | |
| James | | | Lambert | | | Susie | | | Alban | | | | |
| 17 INFORMANT | | | ADDRESS | | | 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| Dorothy Lambert | | | Hampstead R.D. 2 | | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound head</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mental Depression</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>unknown</u> | | | 20 min. (est) | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 976 | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day Year HOUR A.M. ** 11-26 1968 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street factory, office building, etc) home | | | 21f LOCATION Street or R.F.D. No City or Town County State Brick Store Rd. Hampstead Balto Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | ASSISTANT MEDICAL EXAMINER | | | 22b DATE SIGNED | | | | |
| D. D. Caples | | | | | | | | | 11-27-68 | | | | |
| EXAMINER'S NAME (Type) | | | 6 Hanover Rd. | | | REISTERSTOWN, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 11/29/68 | | | Hampstead Cemetery | | | Hampstead Carroll Md. | | | | |
| 24 FUNERAL DIRECTOR | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| John E. Goff Funeral Home | | | 424 N. Main St. Hampstead, Md. | | | DEC 2 1968 | | | Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| 15592 | | | | | | | | | | | | | | | | | |
| 15605 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) HESTER | | | First W. | | | Middle LARKIN | | | Last | | | 2a. DATE OF DEATH Month Nov Day 7 Year 1968 | | | 2b. HOUR 8:10 P.M. | | |
| 3 SEX Female | | | 4 RACE W | | | 5. DATE OF BIRTH May 10, 1891 | | | 6 AGE (In years last birthday) 77 YRS. | | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Arbutus | | | 13d. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 1227 Linden Avenue 21229 | | | | | |
| 14. FATHER'S NAME First Edgar Middle Ingram Last Ingram | | | 15. MOTHER'S MAIDEN NAME First Alice Middle (Unknown) Last (Unknown) | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. None | | | 17. INFORMANT Roland D. Larkin, 1001 St. Charles Ave. | | | Address Baltimore 21229 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Sept Day 19 Year 1967 P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 18, 1967 to Nov 21, 1968 , that (I) (we) lost the deceased on Nov 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE I. Earl Pass | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 11-21-68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) I. Earl Pass | | | 22e. ADDRESS 4001 Wilkens Avenue, Baltimore 21229 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11-23-68 | | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore City, Baltimore Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | ADDRESS | | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | | | | | | |



15594

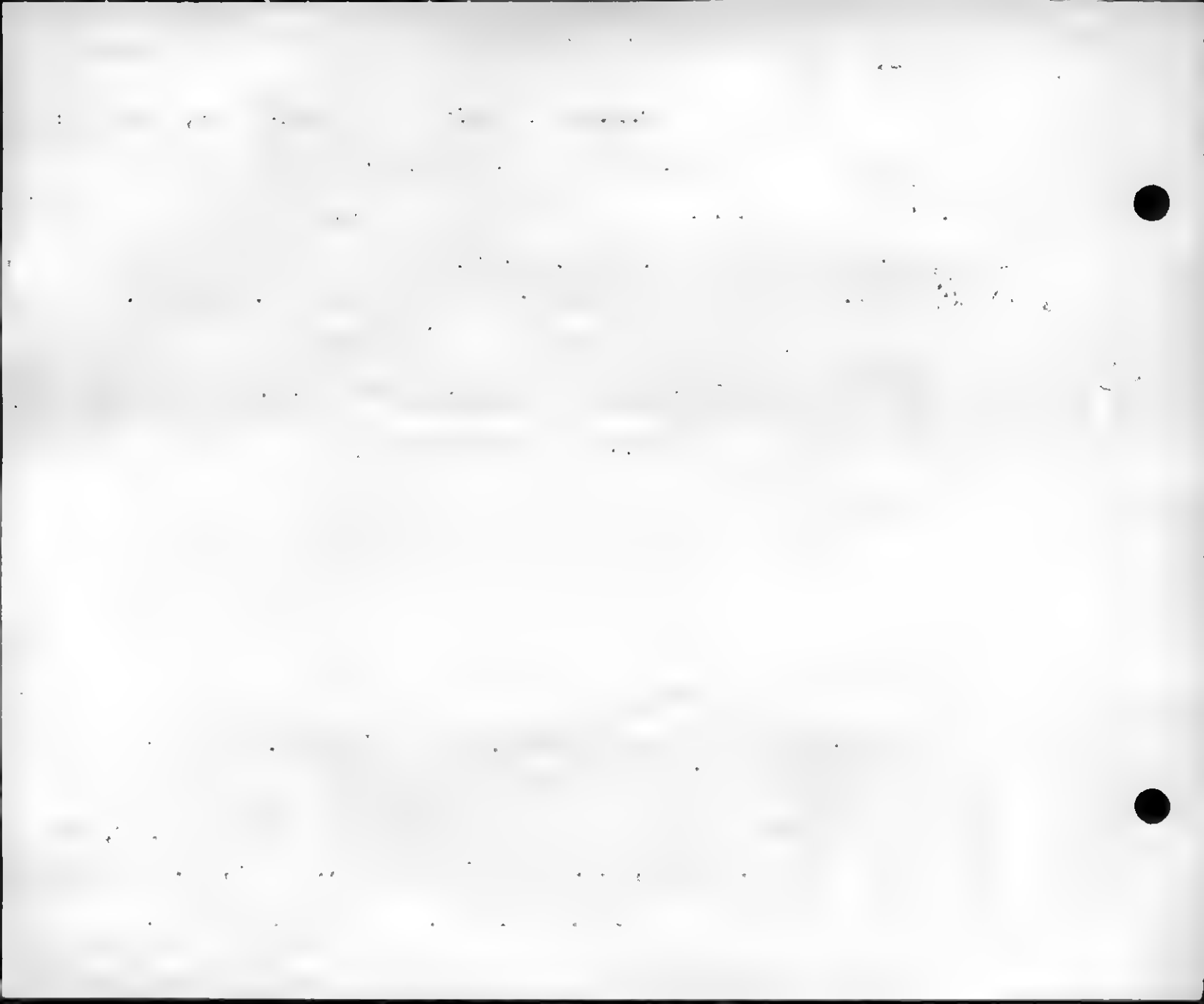
CERTIFICATE OF DEATH

15606

| | | | | | | | | |
|---|--|--|--|---|-------------------------------------|--|----------|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| IDA | | Bertha | LAUGHLIN | | November 29, 1968 | | 4:30 P. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| Female | White | March 24, 1900 | | | 68 | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Baltimore | U.S.A. | | | Baltimore | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | St. Joseph Hospital | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | MD. | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET AND NUMBER | | | | |
| | | Baltimore | | 914 N. Janney St. | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| | | | | Helmbold | unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| | | 212-46-9747 | | Melvin Seidel, son, | | 21221 642 Rockaway Beach | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | 1 1/2 years |
| IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) Ovarian adenocarcinoma | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 1130 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Aug 13, 1968 | | Abdominal Mass | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. City or Town County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1968, to Nov. 29, 1968, that (I) (we) last saw the deceased alive on Nov. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | |
| <i>Antonio G. De Leon M.D.</i> | | | | Nov. 29, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| Antonio G. De Leon, M.D. | | | | 7620 York Rd., Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 12/3/68 | | Balto. Nat. Cem. | | Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR | | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | | DEC 4 1968 | | <i>[Signature]</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

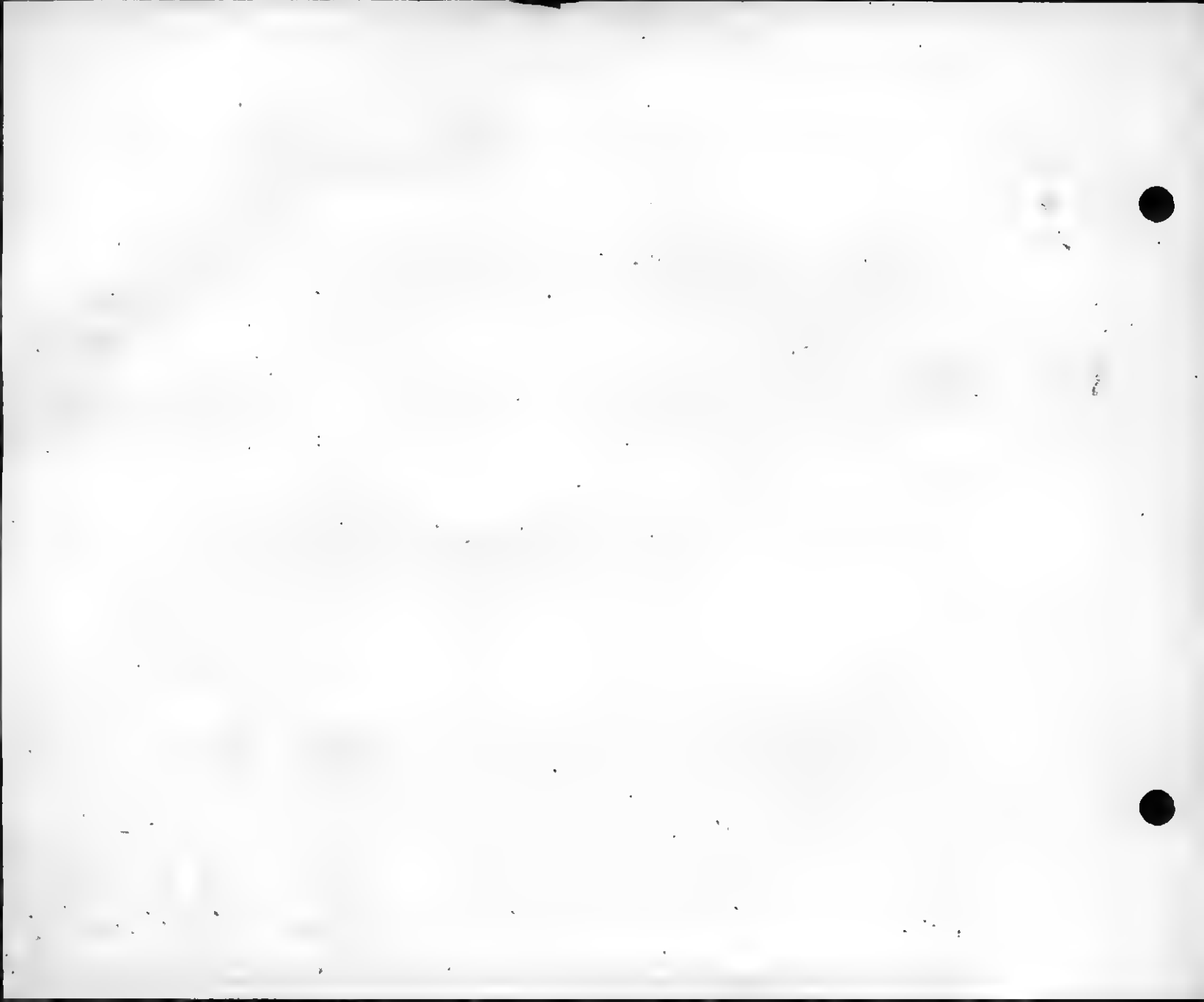
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| 15595 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15601 | | | | | |
|--|--|--|-----------------------------|--|--------------------------|---|--|---|--|--|--|--|--|---|--|------------------|--|----------------------------|--|-------------------------|--|--|--|----------|--|
| 1 DECEASED-NAME (Type or print) | | | | | | | | | | First Middle Last | | | | | | | | | | 2a DATE OF DEATH | | | | 2b HOUR | |
| Charles Irvin Leaf | | | | | | | | | | | | | | | | | | | | Month 11 Day 19 Year 88 | | | | 4:05 A M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | |
| Male | | | White | | | Oct 30, 1886 | | | | 82 YRS | | | | MONTHS | | DAYS | | HOURS MIN | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Maryland | | | United States | | | | | | | Baltimore | | | | | | | | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | Shangri-La | | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | | | | | | | | | | | | | |
| Maryland | | | | Baltimore | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3313 Chestnut Ave | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | |
| Cornelius Leaf | | | | | Christine Klimpert | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | Address | | | | | | | | | | | | | |
| No unknown | | | | 215076696 | | | | Shangri-La | | | | 333 Harlem Lane | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u> | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-11-1968, to 11-15-1968, that (I) (we) last saw the deceased alive on 11-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | DEGREE | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | | | |
| Cesar Valle-Cavero | | | | | | | | | | | | | | | | | | 11-15-68 | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| CESAR VALLE*CAVERO | | | | | | | | | | 8629 Liberty Road | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | |
| Burial | | | | 11-18-68 | | | | Green Meth Cem | | | | Chesnut Ridge Bldg Baltimore Co Md | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Burgess Funeral Home Baltimore Md | | | | | | | | | | | | | | DATE NOV 20 1968 | | | | V. J. ... | | | | | | | |



15598

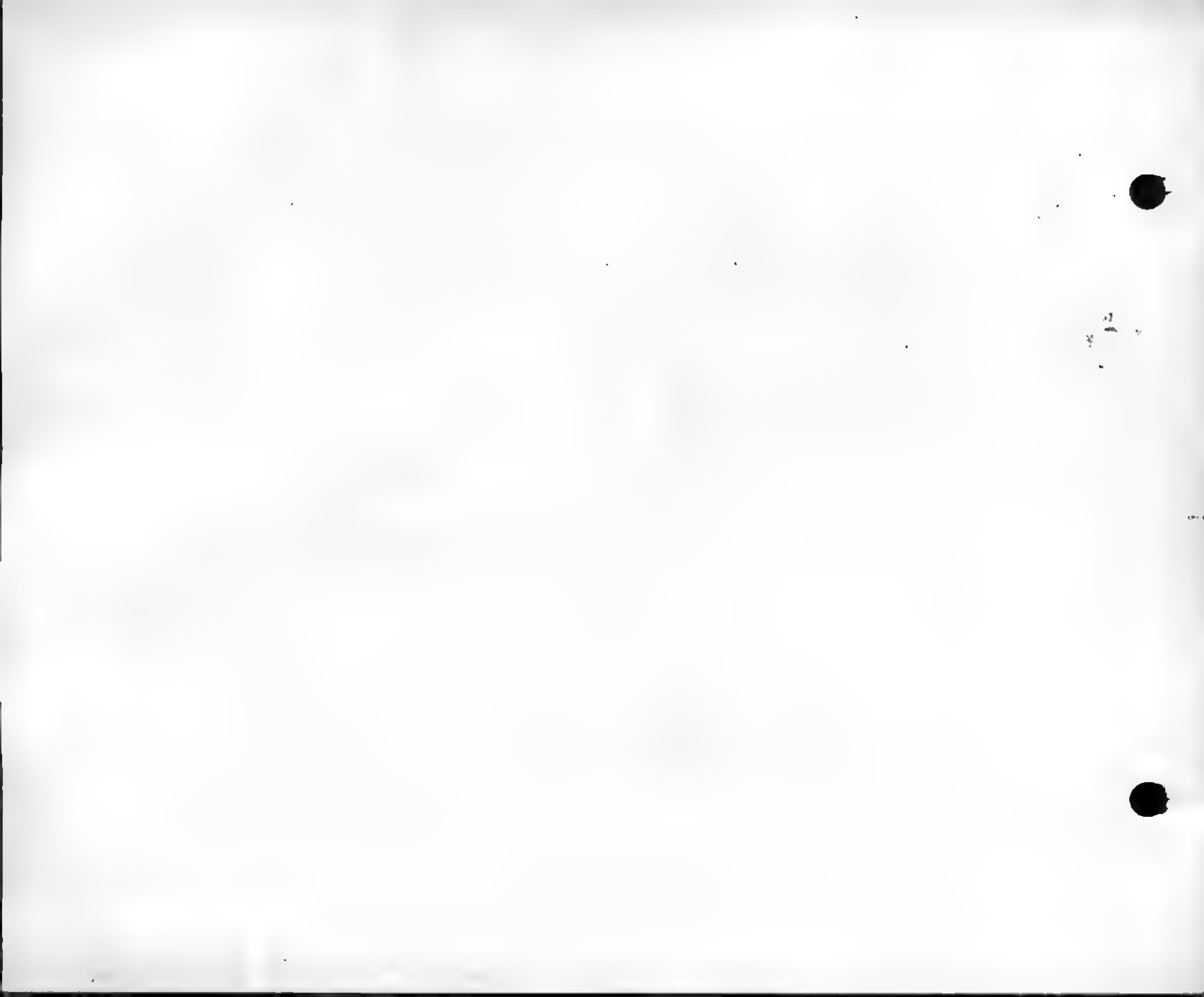
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|-------------------------------------|-----------------------------------|--|--|------|--|
| 1. DECEASED-NAME (Type or print) <i>Rachel</i> | | First | | Middle | | Last | | 2a. DATE OF DEATH Month <i>11</i> Day <i>12</i> Year <i>68</i> | | | 2b. HOUR <i>1:45</i> M | | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>4/13/93</i> | | | 6. AGE (In years last birthday) <i>75</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Poland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore County General</i> | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>8510 Greens lane</i> | | | | | | | |
| 14. FATHER'S NAME <i>Jonas</i> | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME <i>Tannerbaum</i> | | First | | Middle | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> | | 16b. SOCIAL SECURITY NO <i>---</i> | | 17. INFORMANT <i>Chart</i> | | Address | | | | | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>DEGENERATION OF UTERUS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-12</i> , 19 <i>68</i> , to <i>11-12</i> , 19 <i>68</i> ; that (I) (we) last saw the deceased alive on <i>11-11</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph C. Lando</i> | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>11-12-68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Nov 13, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rodman Russ Green</i> | | 23d. LOCATION (City or Town) <i>Balta</i> | | (County) | | (State) <i>md</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, Inc</i> | | ADDRESS <i>9610 Reisterstown Rd</i> | | 25a. REC'D BY REGISTRAR DATE <i>NOV 14 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 14 hours after death.



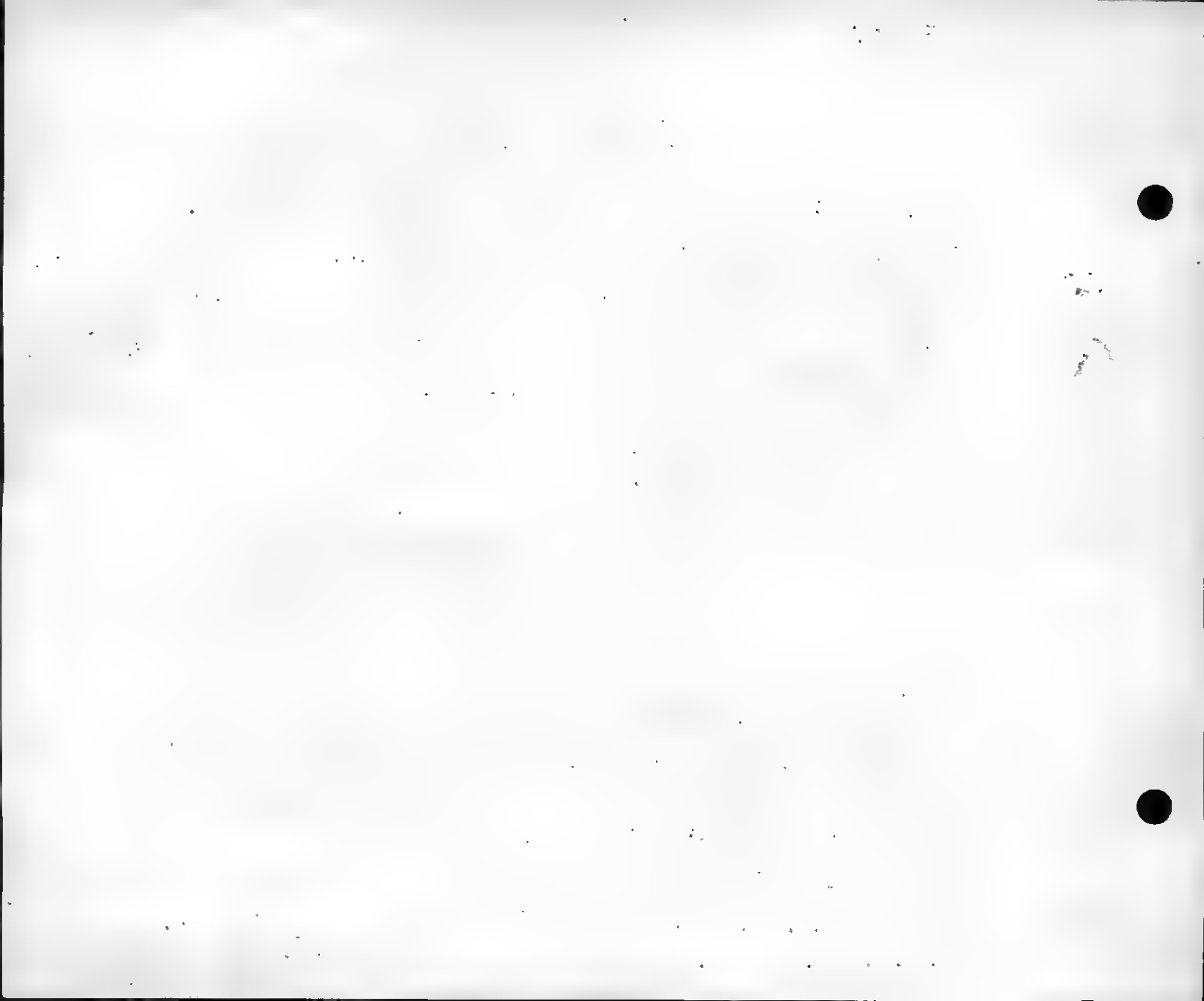
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)
304 REV. 7-68

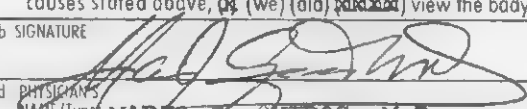

| 15597 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15609 | |
|---|--|--|---|--|--|---|--|--|----------------|---|---|---|--|-------------------------------------|--|---|--|--|--|-------|--|
| Item #6 Film #G407 12/4/68 vmp | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First EARL | | | Middle JAMES | | | Last LESLIE | | | 2a. DATE OF DEATH 11 Month 25 Day 68 Year | | | | 2b. HOUR 7:40 PM | | | | | |
| 3. SEX m | | | 4. RACE w | | | 5. DATE OF BIRTH Oct 5 - 1885 | | | | 6. AGE (In years last birthday) 83 YRS. | | | | 7. UNDER 1 YEAR MONTHS 1 DAYS 20 | | 8. UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Towson, Pa | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH USA - BALTIMORE Md | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hume ARMACOST Nursing | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DENTIST | | | | 12b. KIND OF BUSINESS OR INDUSTRY DENTISTRY | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN TOWSON | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 109 LINDEN TERRACE | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last JAMES | | | 15. MOTHER'S MAIDEN NAME First Middle Last Catherine McGraw | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16b. SOCIAL SECURITY NO. 2 9 - 3 8 - 4 0 0 8 | | | | 17. INFORMANT Family records | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA 7.9 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis & Parkinson's Disease 5 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 1960, to 11-25-68, that (I) (we) last saw the deceased alive on 11-22-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Franklin E. Leslie M.D. DEGREE | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 11-25-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) FRANKLIN E. LESLIE | | | | | | | | | | | | 22e. ADDRESS 3501 St Paul St Baltimore Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Nov. 27, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial | | | | 23d. LOCATION (City or Town) (County) (State) Cockeysville, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland | | | | | | | | | | | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

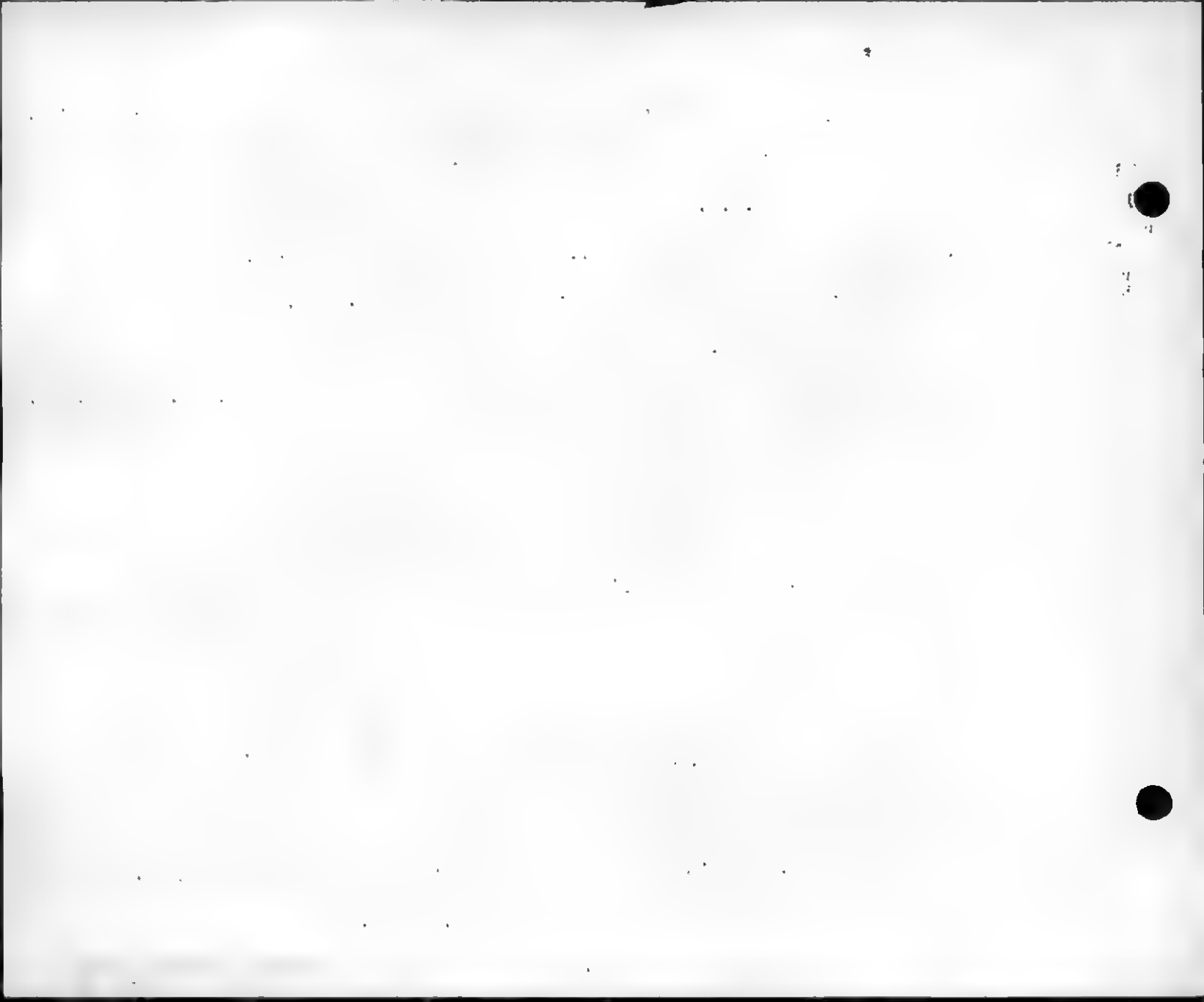
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|---------------------|--|--|---------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First MIRAM | | | Middle NEWTON | | | Last LEWIS | | | 2a. DATE OF DEATH Month November | | | Day 8 | | | Year 1968 | | | 2b. HOUR 9:a. M | | |
| 3 SEX Male | | | 4 RACE White | | | 5 DATE OF BIRTH Jan. 3, 1894 | | | 6 AGE (In years last birthday) 74 | | | IF UNDER 1 YEAR MONTHS 74 | | | IF UNDER 24 HRS HOURS 74 | | | MIN 74 | | | | | |
| 7a BIRTHPLACE (State or foreign country) Ohio | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore | | | Md. | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Ft. Howard | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Adm. Hospital | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tool and Die Maker | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland | | | 13b. COUNTY Carroll | | | 13c CITY OR TOWN New Windsor | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET AND NUMBER Rt. 1 | | | | | | | | | | | |
| 14 FATHER'S NAME First Newton | | | Middle A. | | | Last LEWIS | | | 15 MOTHER'S MAIDEN NAME First Dolly Perry | | | Middle | | | Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | | 16b SOC AL SECUR TY NO (If yes give year or dates of service) WWI | | | 17 INFORMANT 283 03 71 62 Clinical Rcds VA Hospital, Ft. Howard, Md. | | | Address | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS HEART DISEASE | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS MONTHS YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NODULAR PROSTATIC HYPERTOSIS | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Nov. 5 , 19 68 , to Nov. 8 , 19 68 , that (X) (we) last saw the deceased alive on Nov. 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE  | | | DEGREE MARIO J. QUIROS, M.D. | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c DATE SIGNED 11/9/68 | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) MARIO J. QUIROS, M.D. | | | 22e ADDRESS VA Hospital, Fort Howard, Md. | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b DATE 11/11/1968 | | | 23c NAME OF CEMETERY OR CREMATORY LAKEVIEW MEMORIAL PARK CEM. | | | 23d LOCATION (City or Town) (County) (State) Carroll Md. | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR WALTZ FUNERAL HOME, WINFIELD, MD. | | | ADDRESS | | | 25a REC'D BY REGISTRAR NOV 13 1968 | | | 25b REGISTRAR'S SIGNATURE  | | | | | | | | | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15599
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15611

| | | | | | | | | | | | | | |
|--|---------|--|--|---|--------|---|--------------------------|---|---|------------------------------------|------------------------|---|----------|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | | | Month | Day | Year | 2b. HOUR |
| FRANK FRANCIS LIBERTO | | | | | | 11 15 1968 | | | | 12:45 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | Month | Day | Year | 2d. HOUR |
| Male | White | 12/18/13 | 38 5/2 WRS | MONTHS | DAYS | HOURS | MIN | November 15 1968 | | 12:45 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Mississippi | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Balto. | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Balto. | | | Balto. Beltway | | | Supervisor | | | Gen. Motors | | | | |
| 13a. USUAL RES DENCE (Where deceased lived, if institution. Res dence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | | Balto. | | | Balto | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 106 S. Augusta Ave. | | |
| 14. FATHER'S NAME | | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Last |
| Charles Liberto | | | | | | | Late Mary Cascio | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | 21229 | | | |
| no | | 216-01-2144 | | Mrs. Margaret Liberto | | | | 106 S. Augusta Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| CAUSE OF DEATH | | ? P.M. ? 19 68 | | Subject in auto-auto collision | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town | | County | | State | |
| Street | | Balto. Beltway | | Balto. | | Balto. | | Balto. | | Balto. | | Md | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | November 15, 1968 | | | | | |
| Ronald N. Kornblum, M.D. | | | | DEPUTY MEDICAL EXAMINER | | | | | | | | | |
| ADDRESS | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Witzke, 4101 Edmondson Avenue 21229 | | | | Burial | | 11/18/68 | | New Cathedral Cemetery | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | NOV 18 1968 | | | | Charles Judge | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

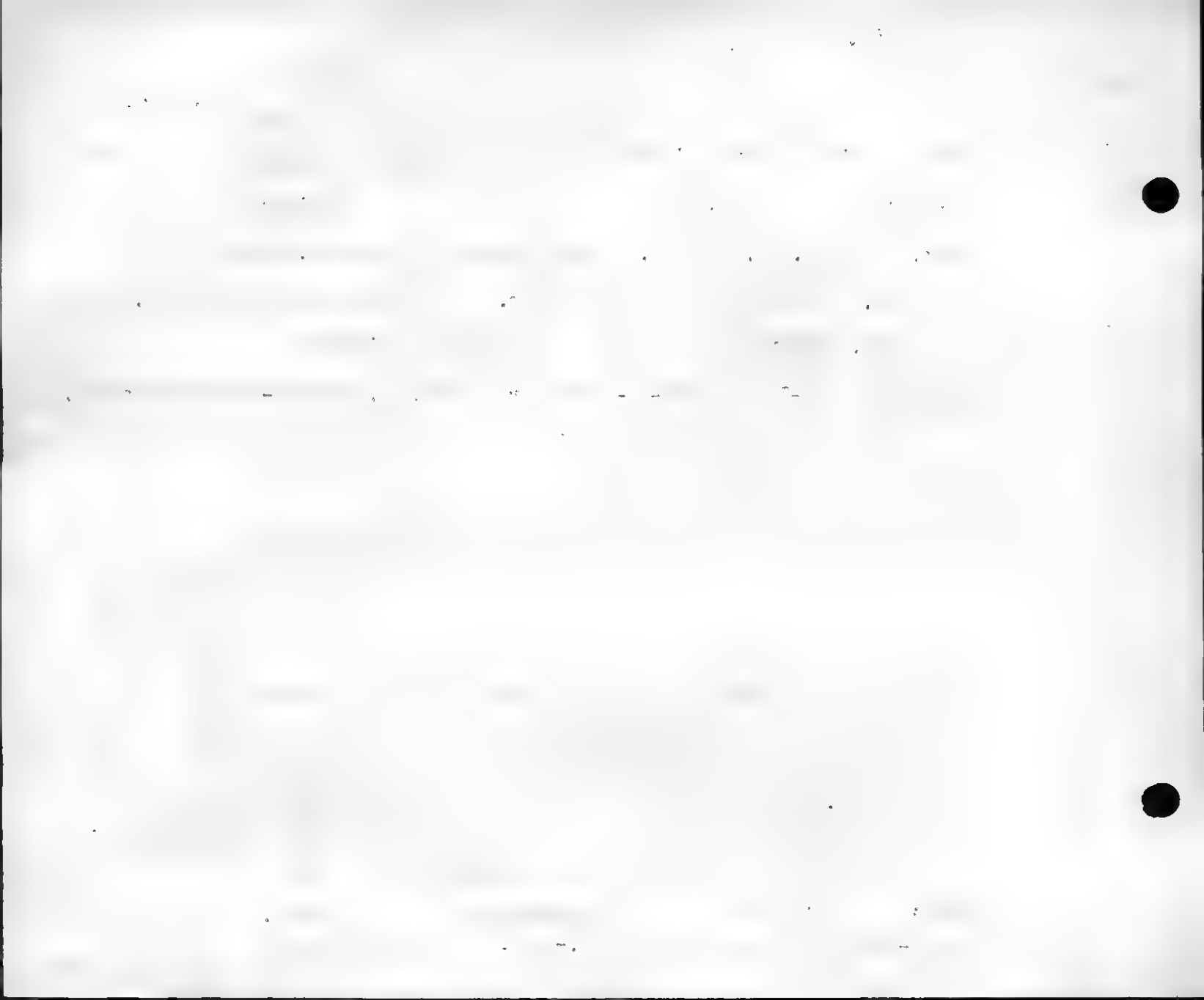
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15600

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1561

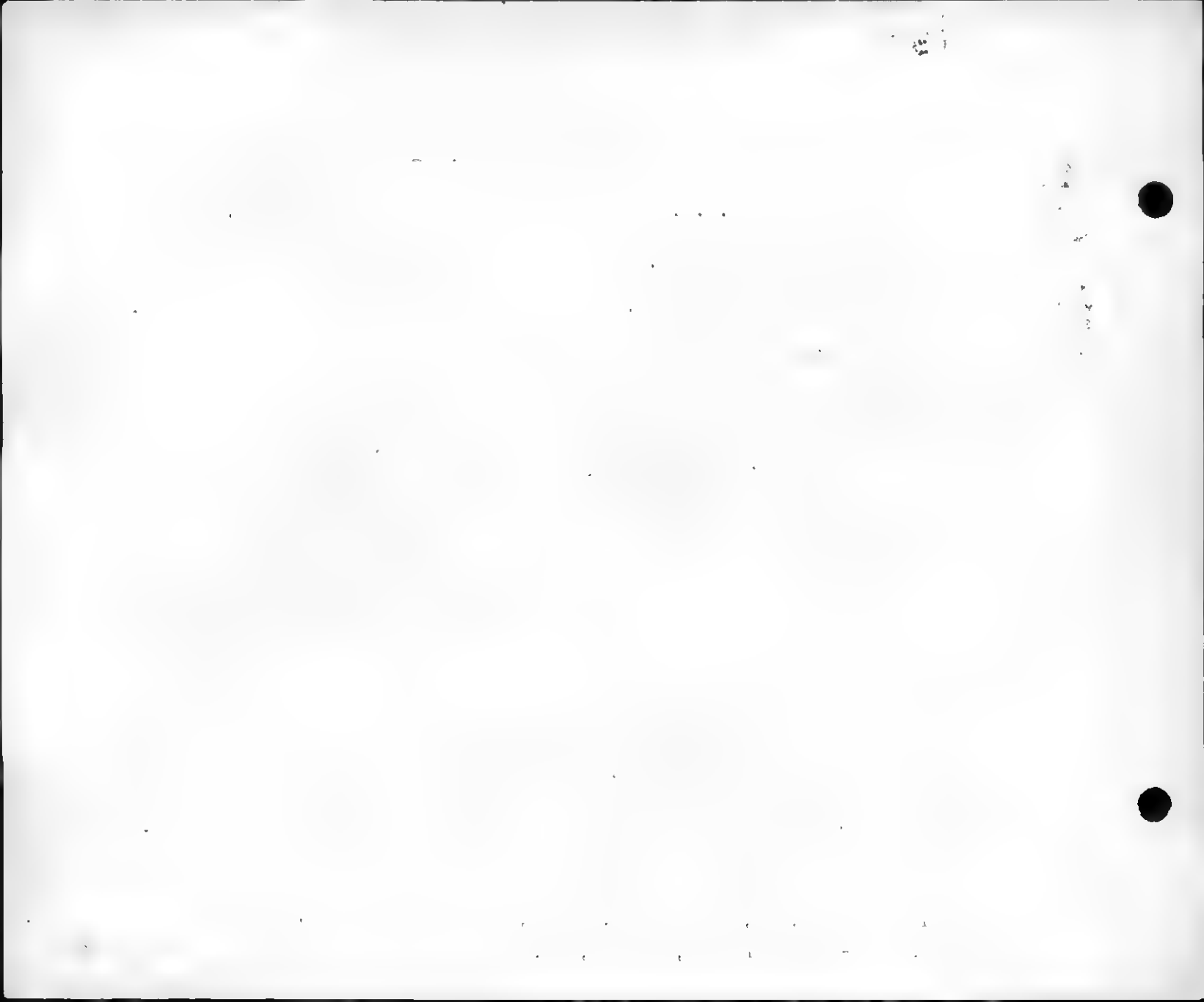
| | | | | | | | | | | | |
|---|--------|-----------------|--|---|-------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | 2b. HOUR | |
| AUBREY RAY LOCKART | | | | | | Month Day Year 11/15/68 19 | | | | M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 1 YEAR | 8 IF UNDER 24 HRS | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Male | White | May 20, 1927 | 41 YRS | MONTHS DAYS | HOURS MIN | Month Day Year 11/ 15 1968 | | | | M | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Oklahoma | | | USA | | | | | | Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USJA. OCCUPATION (Kind of work done during most of work no. life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson, Balto Co. Md. | | | St. Joseph Hospital | | | Sales Mgr. Manpower | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Md. | | | | | | Balto. | | | 6300 Bellona Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John I. Lockart | | | Gertrude Kilgore | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| yes | | | WW-2 | | | 445-22-7836 | | | Mrs. Alvina F. Lockart-6300 Bellona Ave. | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1109 Coronary Occlusion | | | | | | | | | | Sudden | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 420, | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town County State | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| Charles F. O'Donnell | | | Charles F. O'Donnell, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 11/15/68 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 11/18/68 | | | Holy Redeemer Cem. | | | Balto. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REG. STRAR | | | 25b. REG. STRAR'S SIGNATURE | | |
| Mitchell-Wiedefeld Home-6500 York Rd.-21212 | | | | | | DATE NOV 19 1968 | | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15601 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15613 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|---|--|
| 1 DECEASED-NAME (Type or print) Thomas Patrick Loftus | | | | | | 2a DATE OF DEATH Month 11 Day 23 Year 1968 | | | 2b HOUR 3:50 PM | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 8-17-83 | | 6 AGE (In years last birthday) 85 YRS | | 7 UNDER YEAR MONTHS 85 MONTHS | | 7 UNDER 24 HRS DAYS HOURS MIN 85 DAYS 85 HOURS 50 MIN | |
| 7a BIRTHPLACE (State or foreign country) Balto. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Balto. Md | | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Josephs | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | | 13b COUNTY Balto. | | | 13c CITY OR TOWN Timonium | | 13d INS DE CITY, IN TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 207 Treherne Rd. | |
| 14 FATHER'S NAME First Middle Last John Loftus | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Mary McIntire | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT Address Hospital Records | | | | | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Intestinal infarction due to arteriosclerosis and atheromatosis of the mesentery artery. (b) and atheromatosis of the mesentery artery. (c) artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 434-7 XXXXXXXXXXXXXXXXXXXX DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7-... | | | | | | | | | | | |
| 9a DATE OF OPERATION | | | 9b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 68 , to 11-23 , 19 68 , that (I) (we) last saw the deceased alive on November 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE William Cilliani | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c DATE SIGNED November 24, 1968 | | |
| 22d PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | | | | | 22e ADDRESS 7620 York Road, Towson, Maryland 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE Nov. 27, 68 | | | 23c NAME OF CEMETERY OR CREMATORY St. Johns, | | | 23d LOCATION (City or Town) (County) (State) Worcester, Mass. | | |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | | | | 25a REC'D BY REGISTRAR DATE NOV 26 1968 | | | 25b REGISTRAR'S SIGNATURE [Signature] | | |

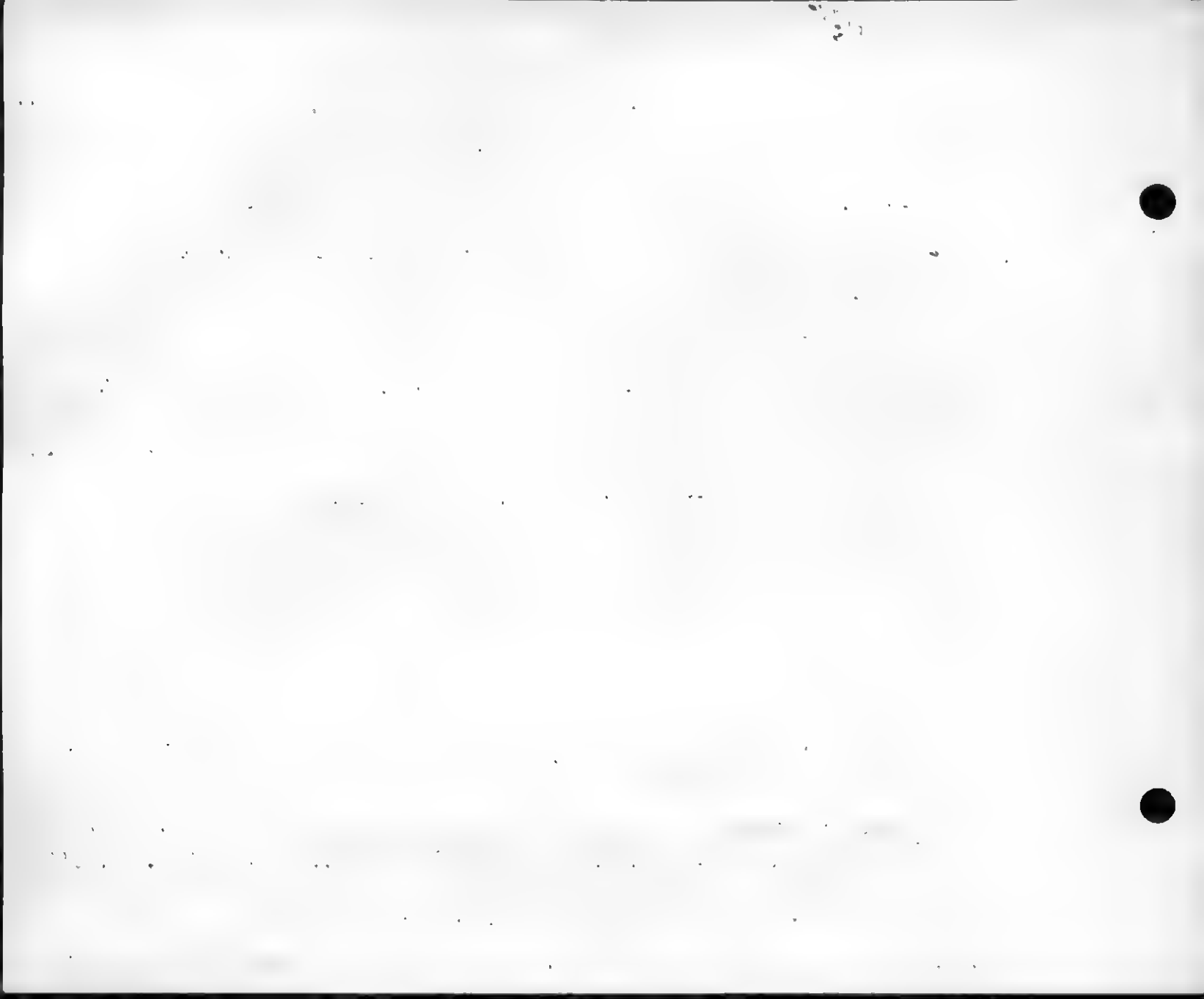


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

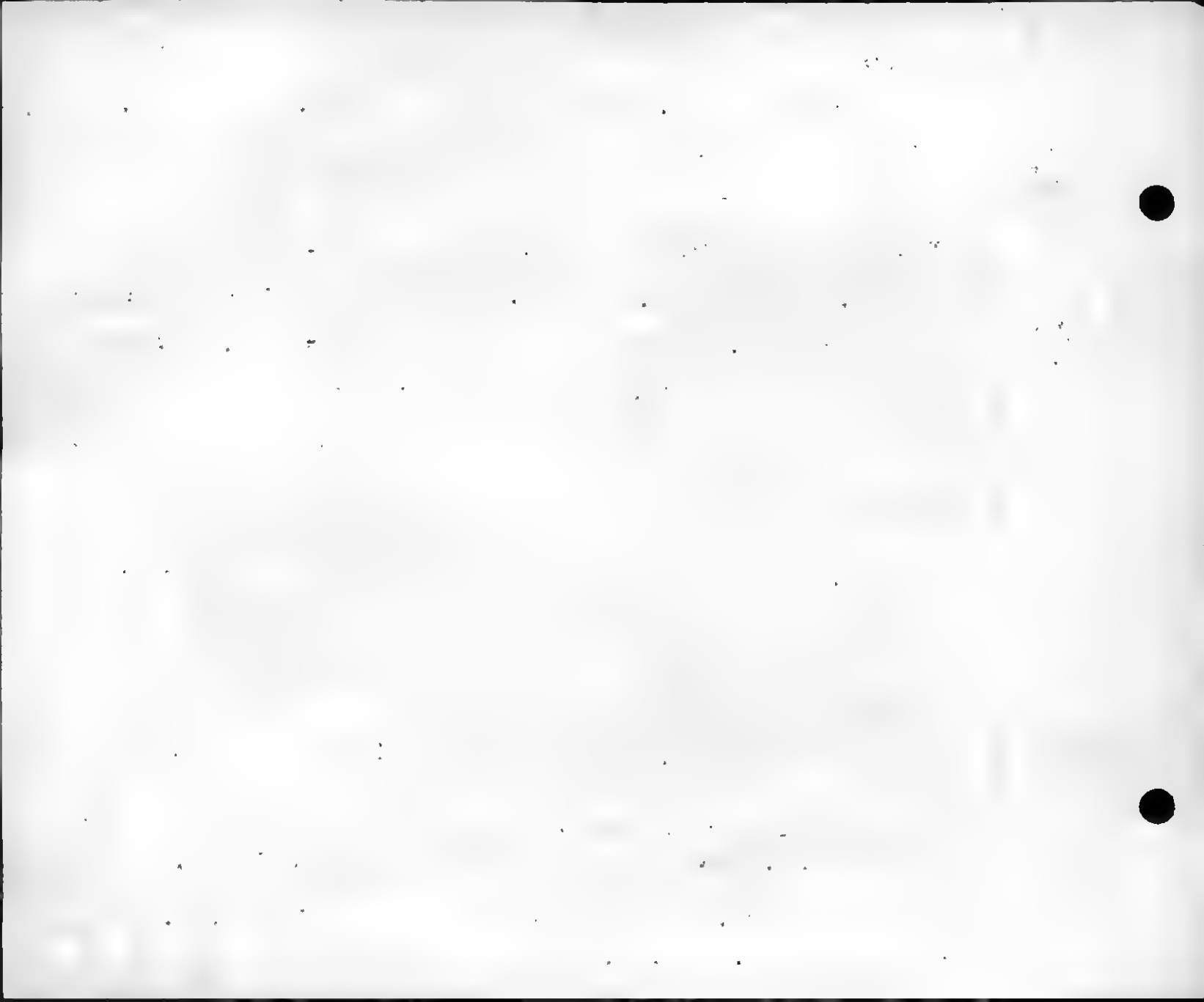
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|----------------------------------|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 15608 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) <i>Frank</i> First <i>B.</i> Middle <i>Long</i> Last | | | | | | 2a DATE OF DEATH <i>Nov.</i> Month <i>22</i> , Day <i>68</i> Year | | | 2b HOUR <i>8 P.M.</i> | | | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH <i>August 19, 1876</i> | | | 6. AGE (In years last birthday) <i>92</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) <i>Old City Pa.</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Crivings Mills, Md.</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4 Bradbury Rd.</i> | | | 12a USUAL OCCUPATION (Kind of work done during most of work life even if retired) <i>Electrical Contractor</i> | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b COUNTY <i>Balto.</i> | | | 13c CITY OR TOWN <i>Crivings Mills</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER <i>4 Bradbury Road</i> | | |
| 14. FATHER'S NAME First <i>William</i> Middle <i>Long</i> Last | | | | 15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>Harsch</i> Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO <i>185-10-8341</i> | | 17 INFORMANT Address <i>Mr. William W. Long Crivings Mills, Md.</i> | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>41-7</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic C.V. disease with cerebral ischemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 to 3 hrs.</i> <i>y ears</i> | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>42-1</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>November</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>October 15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Martin E. Strobel M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c DATE SIGNED <i>Nov. 24, 1968</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i> | | | | | | 22e ADDRESS <i>59 Hanover Rd., Reisterstown, Md. 21136</i> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b DATE <i>Nov. 26, 68</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Montoursville Cemetery</i> | | 23d LOCATION (City or Town) (County) (State) <i>Montoursville Penna.</i> | | | | | | |
| 24 FUNERAL DIRECTOR ADDRESS <i>J. F. Eline & Sons Reisterstown, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 27 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>f Charles Judge</i> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First RUTH | | | Middle E. | | | Last LYNCH | | |
| 2a. DATE OF DEATH | | | Month 18, Day 1968 | | | 2b. HOUR | | | 1 P.M. | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH November 18, 1892 | | | 6. AGE (In years last birthday) 76 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md. | | |
| 10. CITY OR TOWN OF DEATH PARKVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3025 Lavender Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md. | | | 13b. COUNTY Balto. | | | 13c. CITY OR TOWN Balto. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER 3025 Lavender Avenue | | | 14. FATHER'S NAME First Middle Last Henry B. Lynch | | | 15. MOTHER'S MAIDEN NAME First Middle Last Caroline E. Albert | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. None | | | 17. INFORMANT Miss Margaret Lynch | | | Address (Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OVARIAN CARCINOMA</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> , 19 <u>62</u> to <u>11/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>L. P. Berger</u> | | | 22c. DATE SIGNED <u>11/18/68</u> | | | 22d. PHYSICIAN'S NAME (Type) L. P. Berger | | | 22e. ADDRESS 8100 Harford Rd. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/21/68. | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR DATE Nov 19 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

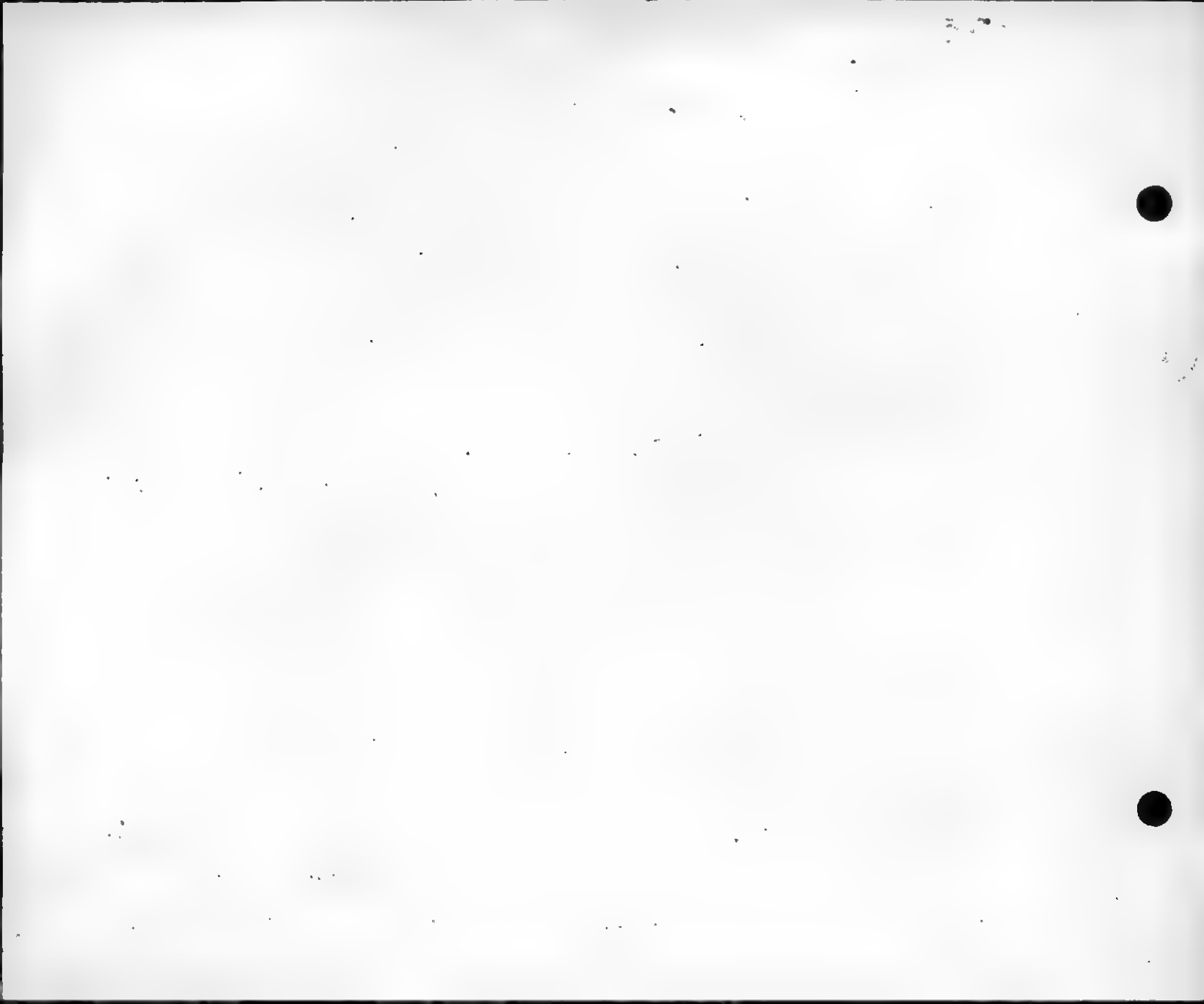
1561

15604.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) EVA W. MALKAK | | | 2a. DATE OF DEATH 11 Month 29 Day 68 Year | | | 2b. HOUR 8:30 P M | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 11/28/82 | | 6. AGE (In years last birthday) 86 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) CANADA | | 7b. CITIZEN OF WHAT COUNTRY? CANADA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTO. CO. Md. | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANNON - LA | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY Unk. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY -- | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Irvington | |
| 14. FATHER'S NAME First JAMES Middle BECKETT Last BECKETT | | | | 15. MOTHER'S MAIDEN NAME First SCOTT Middle SCOTT Last SCOTT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT A.E. MALKAK Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Pulmonary Terminal DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 1120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 11 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 57 , to 11/29 , 19 68 , that (I) (we) last saw the deceased alive on 11/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Eliot W. Johnson MD DEGREE MD | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11/30/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) E.S. MALINABA | | | | 22e. ADDRESS 3432 Frederick Ave Baltimore Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION (City or Town) (County) (State) BALTO. MD | | | |
| 24. FUNERAL DIRECTOR E.S. MALINABA ADDRESS 212 28 | | | | 25a. REC'D BY REGISTRAR 1968 DATE DEC 3 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

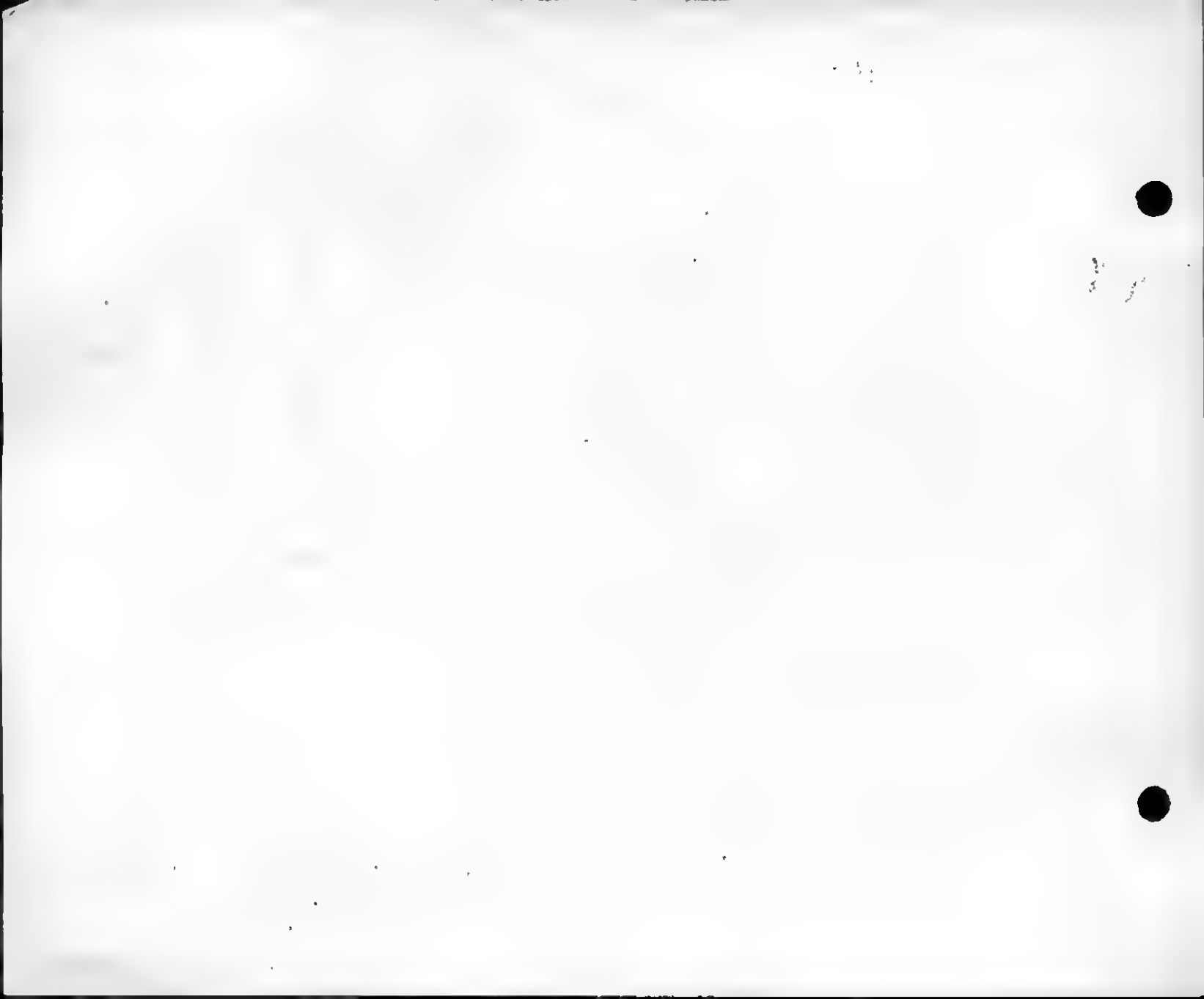
15605

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15618

| | | | | | | | | | | | |
|---|--|------------------------------|---|---|---|---|------------------------------|--|--------------------------------------|------------------------|------|
| 1 DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Scott | | | Anthony | Maki | Month 11 Day 24 Year 1968 | | | 240 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | 7. UNDER YEAR | | 8. UNDER 74 HRS | |
| Male | | White | | June 24, 1968 | | YRS. MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore, | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | St. Joseph Hospital | | | N/A | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1708 W. Rogers Ave. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| | | | | | | Carol | | | Lee | Heatterick | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | |
| | | | | | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalopathy</u> <u>742 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Internal hydrocephalus</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>752 X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>10/8/</u> , 19 <u>68</u> , to <u>11/24/</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>11/24/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>William</u> | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED <input type="checkbox"/> STAFF DIRECTOR PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>12/2/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Ines Cilliani, M.D.</u> | | | | | | 22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u> | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE <u>12-6-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>U of Md Med School</u> | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| | | | | | | | Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | DATE <u>DEC 16 1968</u> | | <u>Charles Judge</u> | | | |

VR A15
45M-1168

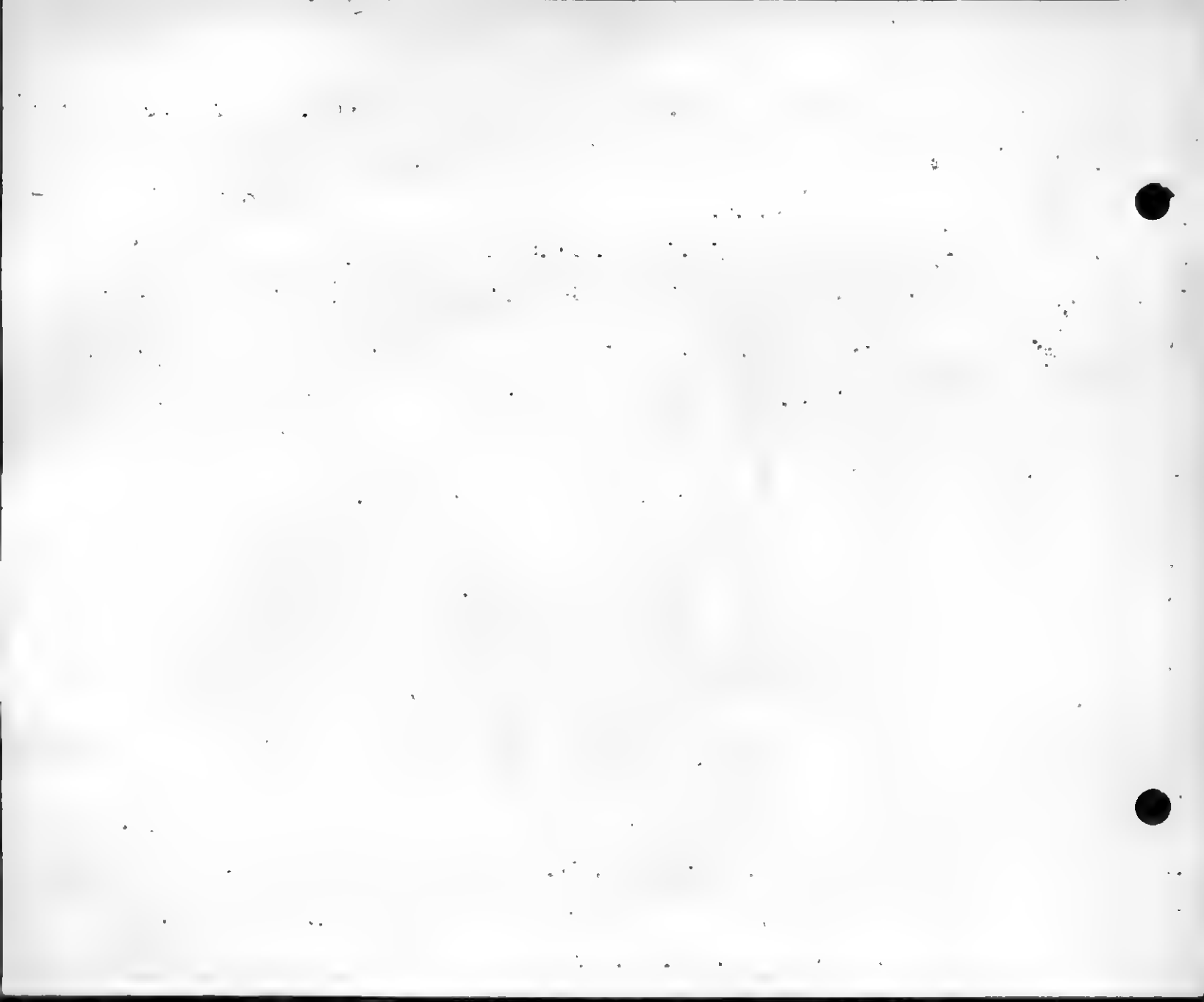


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

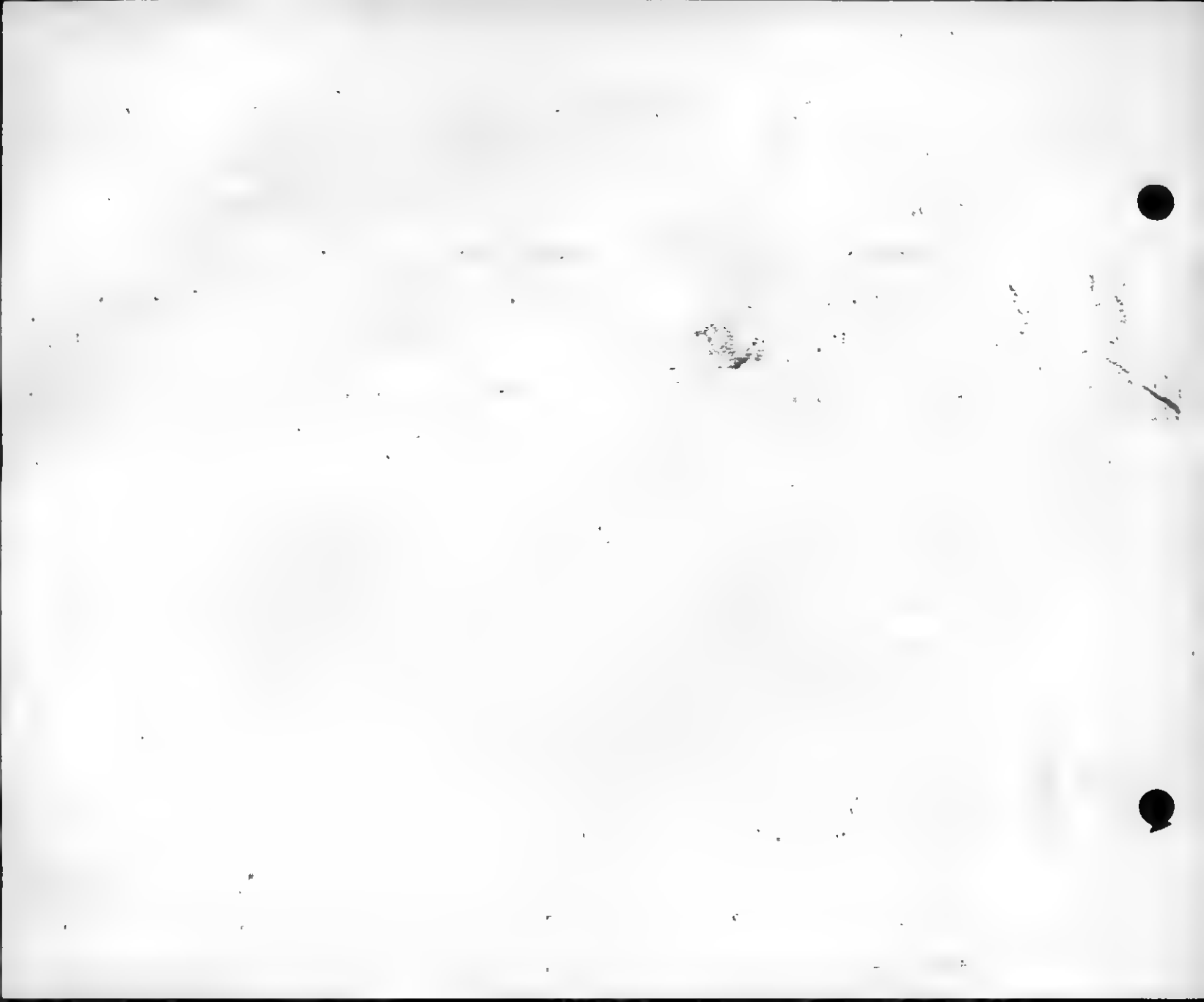
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|---|---|--|---|---|------------------------|---|
| 15606 | | CERTIFICATE OF DEATH | | | | | | 15619 | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| LEVAN | | | P. MANCHEY | | | NOV. Month 18 Day 68 Year | | | 7:25 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR MONTHS DAYS |
| MALE | | WHITE | | March 15, 1915 | | | 53 YRS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | | BALTIMORE Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | | | GR. BALTO. MED. CENTER | | | Accountant | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD. | | | | | BALTIMORE | | | 2808 KINGSRIDGE ROAD | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| George T Manchey | | | Hattie Redding | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | WW II | | Mrs Shirley P Manchey | | Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reticulum Cell Sarcoma</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gland, bone, lung involvement.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| <u>Acute duodenal ulcer.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1964</u> , 19____, to <u>Death</u> , 19____, that (I) (we) last saw the deceased alive on <u>November 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Crawford N. Kirkpatrick, Jr.</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>11-18-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Crawford N. Kirkpatrick, Jr.</u> | | | | 22e. ADDRESS <u>6 East Eager Street - City 21202</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| <u>Burial</u> | | <u>11/21/68</u> | | <u>Parkwood</u> | | <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC. BALTO. MD. 21214</u> | | | | 25. DATE BY REGISTRAR <u>NOV 19 1968</u> | | 25b. REGISTERED SIGNATURE <u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|------------------------------------|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>William Manning</i> | | | | | | 2a. DATE OF DEATH Month <i>November</i> Day <i>7</i> Year <i>1968</i> | | | 2b. HOUR <i>8:30 AM</i> | | |
| 3 SEX <i>M</i> | | 4 RACE <i>W</i> | | 5. DATE OF BIRTH <i>JAN. 1895</i> | | 6. AGE (In years lost birthday) <i>73</i> YRS. | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore Md.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Reisterstown</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bent Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clerk at Produce Terminal</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i></i> | | 13c. CITY OR TOWN <i>Balto.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>2600 Greenmount Ave.</i> | | |
| 14. FATHER'S NAME First <i>John T.</i> Middle <i></i> Last <i>Manning</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i></i> Last <i>O'Hara</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> | | 16b. SOCIAL SECURITY NO. <i>W.W.I none</i> | | 17. INFORMANT <i>Mrs. Margaret F. Severin</i> | | | | Address <i>972 North Hill Rd.</i> | | #21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - right lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Emphysema - Chronic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis (V Disease - Chronic)</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i> <i>years</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>422</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-10, 1968</i> to <i>11-7, 1968</i> , that (I) (we) last saw the deceased alive on <i>11-6, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>C. E. McWilliams MD</i> | | | | | | 22c. DATE SIGNED <i>11-7-68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>1190 Reisterstown Rd Reisterstown Md</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11/9/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i> | | 23d. LOCATION (City or town) (County) (State) <i>Balto. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home 6500 York Rd. #21212</i> | | | | | | 25a. REC'D BY REGISTRAR <i>NOV 18 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15608

1

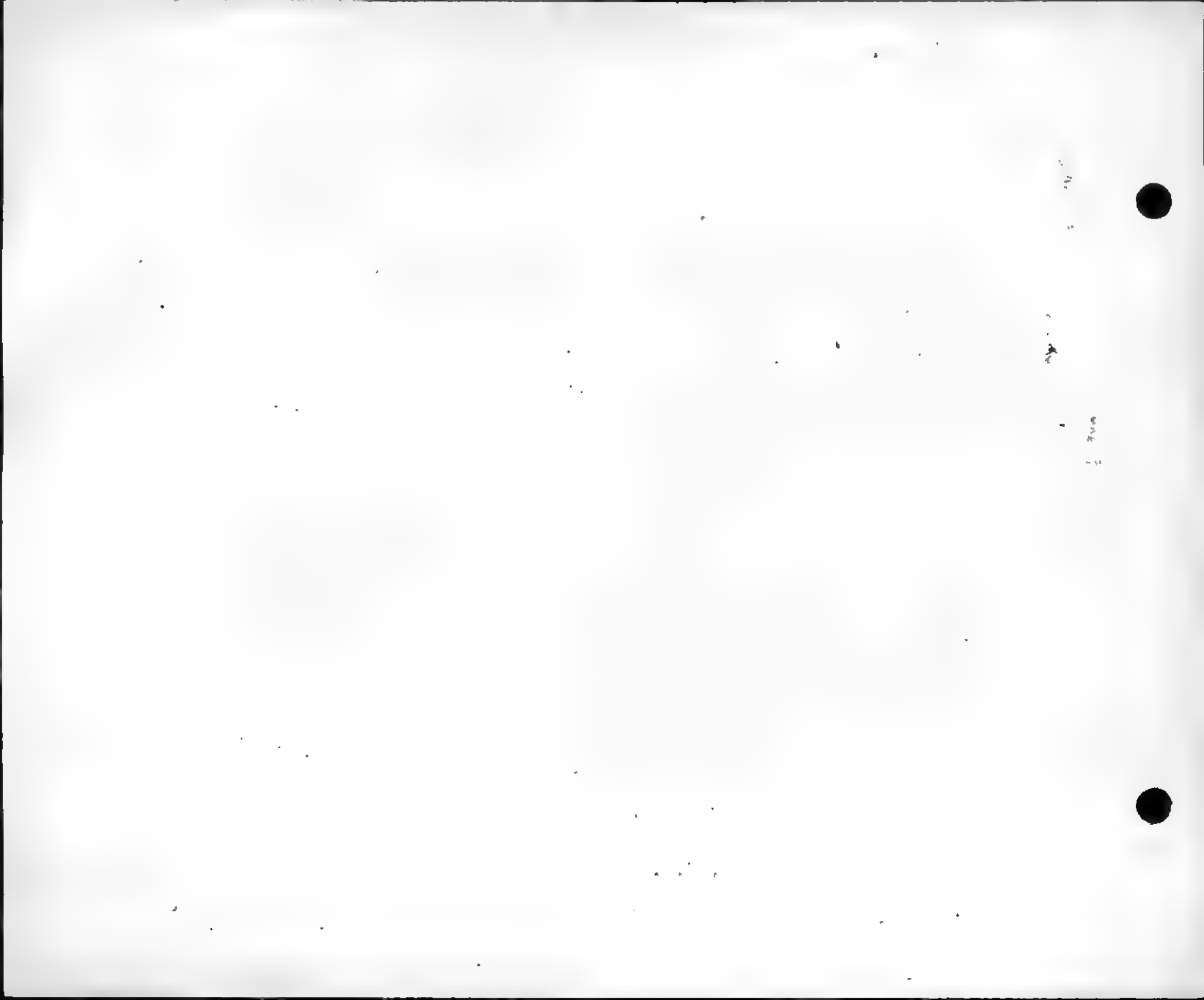
3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15621

| | | | | | | | | |
|--|------------------------------|---|-------------------|--|-----------------------------------|---|-----------------------|---|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Kenneth | | F | | MARSTELLER, Jr | Month 11 Day 19 Year 1968 | | 12 30 PM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | | 6 AGE (in years last birthday) | | 7. UNDER 24 HRS | |
| Male | White | October 3, 1939 | | | 29 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | Baltimore, | | Md | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | St. Joseph Hospital | | Electrician | | Eastern | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before address on) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. RESIDE OUT 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| Maryland | | A.A. | Pasadena | | 313 Delma Ave. | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S M.A.D.E.N. NAME | | First | Middle |
| Kenneth F. Marsteller | | | | | Wanda Lechonsky | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| No | | 216 367649 | | Jugene Marsteller - Alone | | | | |
| 8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic renal failure | | | | | | | | |
| 582X DUE TO, OR AS A CONSEQUENCE OF (b) Chronic glomerulonephritis | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 592X | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 10/1/68 | | Chr. pyelonephritis | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11/1968, to 11/19/1968, that (I) (we) last saw the deceased alive on 11/19/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | 22e. DATE SIGNED | | |
| Samuel Lee, M.D. | | 76 | | Rd., Towson, Md. 21204 | | 11/19/68 | | |
| 23a. BURIAL OR CREMATION (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) |
| Buried | | 11/22/68 | | Landon Park Cem | | Baltimore | | Md |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Robert S. Bananer | | 25c. DATE | | 25d. REGISTRAR'S SIGNATURE | | | | |
| 157800000 | | NOV 25 1968 | | Charles J. Jones | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
304 REV. 1/68

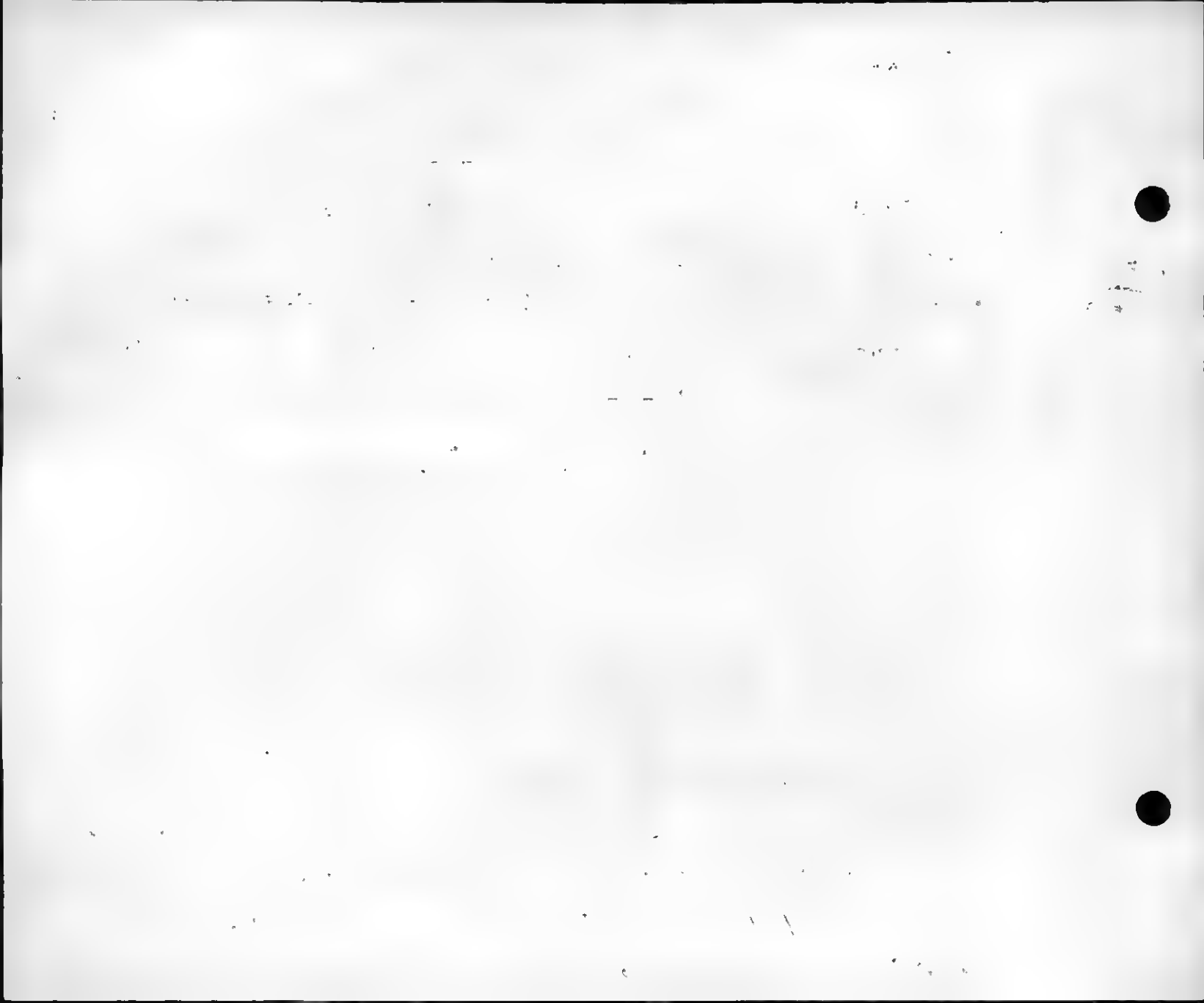
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15609

CERTIFICATE OF DEATH

1562

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last JULIA LOUISE MARTIN | | | 2a. DATE OF DEATH Month Day Year November 23 1968 | | 2b. HOUR 5:45 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 2-28-1899 | | 6. AGE (In years last birthday) 69 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPAR. <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Towson #4 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 5202 Plainfield Avenue | |
| 14. FATHER'S NAME First Middle Last Christian Schmidt | | 15. MOTHER'S MAIDEN NAME First Middle Last Barbara Schell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO. 220-22-2949 | | 17. INFORMANT Address Mrs Julia I. Smith Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized purulent peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF <u>perforated chronic gastric ulcer</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 47 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18, 1968</u> , to <u>Nov. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Ines Cilliani</i> | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Nov. 23, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | 22e. ADDRESS 7620 York Road, Towson 4, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11/27/68 | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

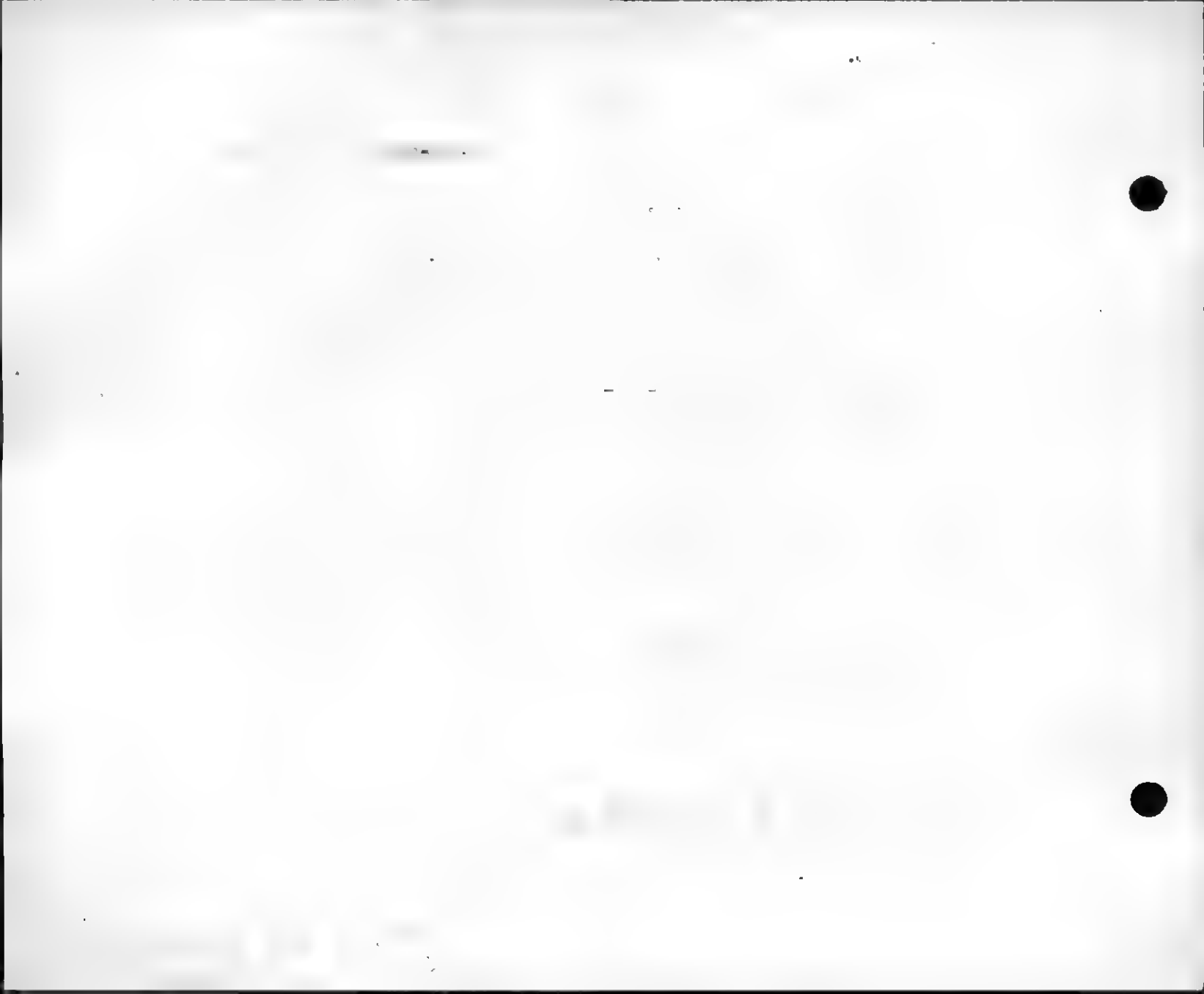


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1 DECEASED NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
|---|--|--|--|--|--------|--|------------------------|--|-----------------------------------|----------------------------|-----------------|--|--|--|
| MERTHA (Bertha) MASON | | | | | | | 11 Month 3 Day 68 Year | | | | 7:10 P M | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| FEMALE | | NEGRO | | 6-23-07 | | | 61 RS | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | |
| Virginia | | U.S.A. | | | | | BALTIMORE Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BALTIMORE | | | GREAT. BALT. MED CENT. | | | Domestic | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before address on) STATE | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIM TSP | | 13e. STREET AND NUMBER | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1324 McCulloh St. | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Tom | | | Wiley | | | Gallie Morton | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | Address | | | | | |
| No | | | | 214-24-3730 | | Mattie Holcomb | | | Wash. D. C. 3737 North J. St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE | | | | | | | | | | | | | | |
| 4319 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 331 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1/68, 19, to 11/3, 19 68, that (I) (we) lost saw the deceased alive on 11/3, 19 68 and that in (my) (our) opinion death occurred on the date and hour one from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | |
| D. G. Caralis MD | | | | | | | | | | | | 11-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e. ADDRESS | | |
| D.G. CARALIS, M.D. | | | | | | | | | | | | GREAT. BALT. MED CENT. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | |
| Burial | | 11-8-68 | | Mt. Auburn Cemetery | | Baltimore | | | | Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. NOV 17 1968 | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Nutter's Funeral Home | | | | | | 3035 W. North Ave | | DATE | | Johnas Judge | | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be sent, within 72 hours after death.

VR 44
45M 69

| <div style="display: flex; justify-content: space-between;"> 15611 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15624 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | | |
|--|--|------------------------|---|---|--------------------------------------|---|---|--|--|----------------------------------|---|--------------------------|
| 1. DECEASED-NAME (Type or print) | | | First Robert | | Middle John | | Last Mason | | 2a. DATE OF DEATH Month November Day 24 Year 1968 | | | 2b. HOUR 10:40 |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH November 19, 1968 | | | 6 AGE (In years lost birthday) YRS 5 | | IF UNDER 1 YEAR MONTHS 5 DAYS 5 | | IF UNDER 24 HRS HOURS 5 MIN 40 | |
| 7a BIRTHPLACE (State or foreign country) Baltimore | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md | | | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 4807-A Bayonne Ave. #21206 | | | |
| 14 FATHER'S NAME First Michael Middle Anthony Last Bullis | | | 15 MOTHER'S MAIDEN NAME First Frances Middle Eileen Last Mason | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | |
| 17 INFORMANT Noop. Ric. | | | 17 ADDRESS | | | 17 ADDRESS | | | 17 ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Subdural and subarachnoid hemorrhage 1120 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a I certify that (A) (this hospital) attended the deceased from November 19, 1968 to November 24, 1968 , that (X) (we) last saw the deceased alive on November 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE Christina Feliciano, M.D. | | | 22c DATE SIGNED November 24, 1968 | | | 22d ADDRESS 7620 York Road, Towson, Md. 21204 | | | | | | |
| 23 BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE 11-26-68 | | | 23c NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | | 23d LOCATION (City or Town) (County) (State) OLD FREDERICK RD. Md. | | | |
| 24 FUNERAL DIRECTOR Krause Funeral Home | | | 24b ADDRESS 1216 D. Charles St. | | | 24c REC'D BY REGISTRAR DATE NOV 29 1968 | | | 24d REGISTRAR'S SIGNATURE J. Charles Judge | | | |



1561B

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #5, Film 74.06 11/20/68 km

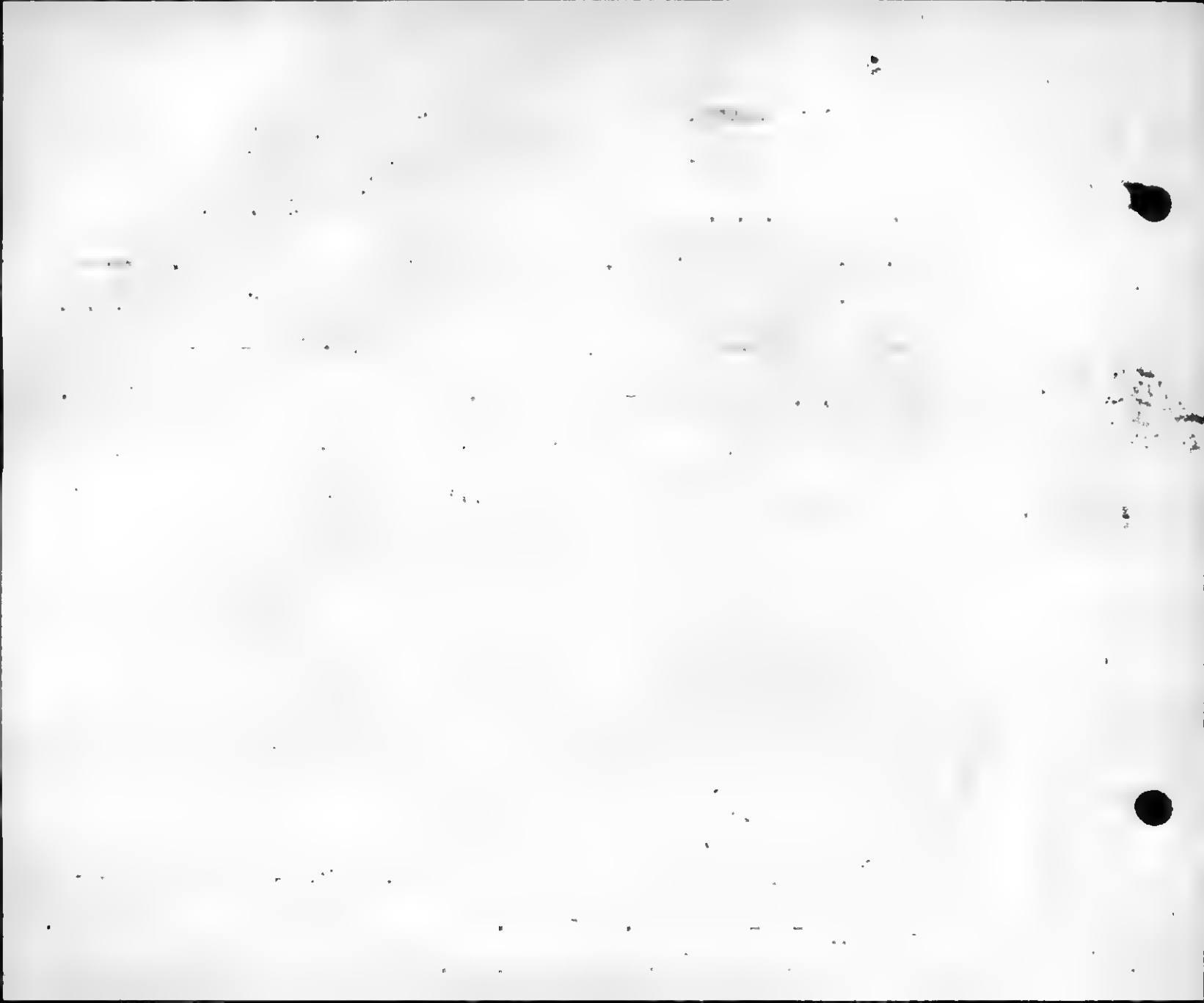
CERTIFICATE OF DEATH

1562

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Horace Leroy McClaine | | | 2a. DATE OF DEATH Month Day Year 11 17 68 | | | 2b. HOUR 8:20-AM | |
| 3 SEX Male | | 4 RACE Colored | | 5. DATE OF BIRTH 8/18/1889/1890 | | 6 AGE (In years last birthday) 78 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Balto. County Md. | |
| 10. CITY OR TOWN OF DEATH Balto. Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in Pines, Catonsville | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY General | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Rising Sun | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last Stephen --- McClaine | | 15. MOTHER'S MAIDEN NAME First Middle Last Martha --- Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. I | | 16b. SOCIAL SECURITY NO. 218--18-2336 | | 17 INFORMANT Mrs. Ann Brady | | Address Nottingham, Pa. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 1530 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1225 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4231 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-6-1967, to 11-11-1968, that (I) (we) last saw the deceased alive on 11-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Wilmer K. Ballager, M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-11-68 | |
| 22d. PHYSICIAN'S NAME (Type) Wilmer K. Ballager, M.D. | | | | 22e. ADDRESS 6209 Frederick Ave. Balt., Md. 21238 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zoar Cem. | | 23d. LOCATION (City or Town) (County) (State) Conowingo Cecil Md. | |
| 24. FUNERAL DIRECTOR Conning M. Miller | | | | ADDRESS Rising Sun, Md. | | 25a. REGD BY REGISTRAR NOV 18 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

17

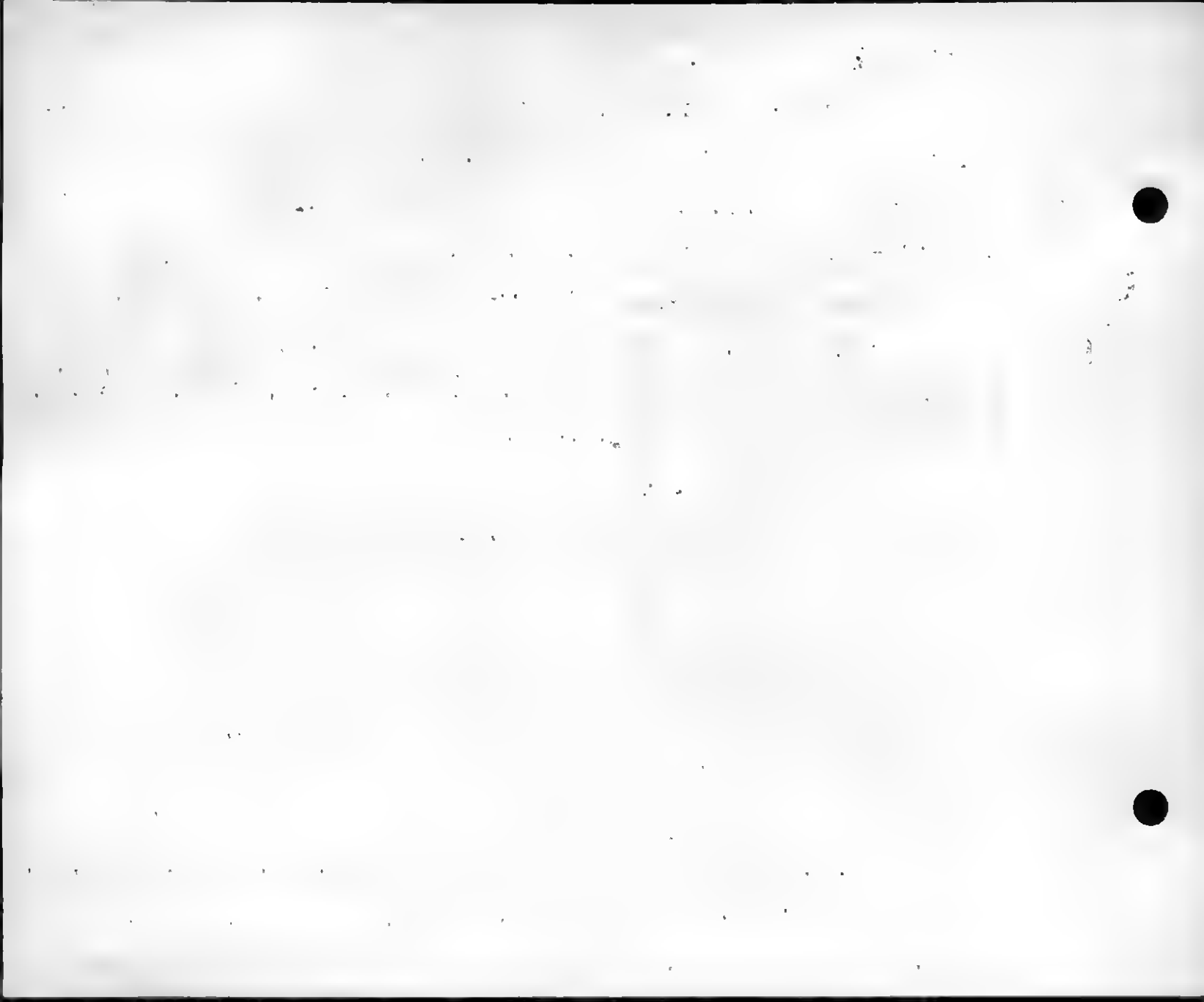
15618

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15626

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|---|--------------------------------|--|--|---|--|
| 1. DECEASED-NAME (Type or print) | | First CALVIN | | Middle COOLIDGE | | Last MCDANIEL | | 2a. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>68</u> | | | 2b. HOUR <u>1:05</u> M <u>pm</u> | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH Aug. 19, 1923 | | | 6. AGE (in years last birthday) 45 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE-Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital or institution) GREATER BALTO., MED. CEN. | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Local #11 | | | 12b. KIND OF BUSINESS OR INDUSTRY Asbestos Worker | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 2517 S. Marine Ave. | | | | | |
| 14. FATHER'S NAME First Middle Last Benjamin J. MCDANIEL | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Hattie L. Estes | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes | | (If yes give war or dates of service) WWII | | 16b. SOCIAL SECURITY NO 216-18-4673 | | 17. INFORMANT (Mother) Address Edgemere, Md. Mrs. Hattie L. McDaniel, 2517 S. Marine Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF SPENIC FLEXURE DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEARTFAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>68</u> , to <u>11/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>A. Pirnia</i> | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/11/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. A. PIRNIA MD | | | | | | | | 22e. ADDRESS Greater Balto. Med. Center, Towson, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park | | | 23d. LOCATION (City or Town) (County) (State) Dorsey, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 15 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-58
30M REV. 7-68

| <div style="display: flex; justify-content: space-between;"> 15614 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15627 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | | |
|---|--|--|-------------------|--|---|---|-----------------------------------|-------------------------------------|-------------------------------|---|-------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M | | | |
| WILLIAM HOWARD McLEAN, Sr. | | | | | | 11/6/68 | | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6 AGE (in years last birthday) | | 7 UNDER 1 YEAR MONTHS DAYS | | 8 UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | 8-12-1888 | | | 80 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | Md | | | |
| Balto., Md. | | USA | | | | Baltimore | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Towson, Balto. Co. | | 9010 Satyr Hill Rd. | | | Office clerk | | | E.A. Keastner Co. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- admission) STATE | | 13b. CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | | | | |
| Md. | | Baltimore | | | | 9010 Satyr Hill Rd. | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Moses McLean | | | | Margaret Hooper | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| no | | | | | | Mr. Stewart H. McLean-9010 Satyr Hill Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | | 1-2 hrs | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) <u>Coronary CVD</u> | | | | | | | | | | 10 yrs | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) <u>4201</u> | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| <u>Viral Negativum Infection</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 July</u> , 19 <u>66</u> , to <u>6 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5 Nov</u> , 19 <u>66</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | |
| <u>Howard Goodman</u> | | | | | | | | 7 Nov 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | |
| | | | | 8604 Harford Rd. | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | 11/8/68 | | London Park Cemetery | | Balto., Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Mitchell-Wiedefeld Home-6500 York Rd., 21212 | | | | DATE NOV 12 1968 | | <u>Charles Judge</u> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1-69

| <div style="display: flex; justify-content: space-between;"> 15615 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15623 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | | | |
|---|--|--------|---|-----------------|--|--|--------------------------------|--|---|--|-----------------|--|--|
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Arthur Andrew MEISE | | | | | | Month Day Year 11 19 1968 | | | 8:55A M | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | White | | August 30, 1900 | | | 68 YRS. | | MONTHS DAYS | | HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Maryland | | | U.S.A. | | | | | | Baltimore, Md | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Towson | | | St. Joseph Hospital | | | Retired | | | Shipping Cle | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET AND NUMBER | |
| Maryland | | | | | | Baltimore | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 2 Henry Ave. | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| John Henry Meise | | | Richard Glotzel | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | Address | | | | |
| NO | | | 219-10-7354 | | | Gladys Clemente | | | 9120 Simms Avenue | | | 21234 | |
| 18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| (b) Pulmonary Thrombo Embolism | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) Thrombosis of the right auricle | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 2d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 11/16/ 1968, to 11/19/ 1968, that (I) (we) lost the deceased alive on 11/19/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | |
| 22b SIGNATURE | | | 22c DATE SIGNED | | | | | | | | | | |
| Ines Cilliani, M.D. | | | 11/19/68 | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | | | | | | | | | |
| | | | 7620 York Rd., Towson, Md., 21204 | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 11-22-1968 | | | St. Peters Luth Cemetery | | | Fullerton Balto. Md | | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lassahn Funeral Home | | | 7401 Belair Road | | | 25a. NOV 22 1968 | | | 25b. [Signature] | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15620. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit receipt. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

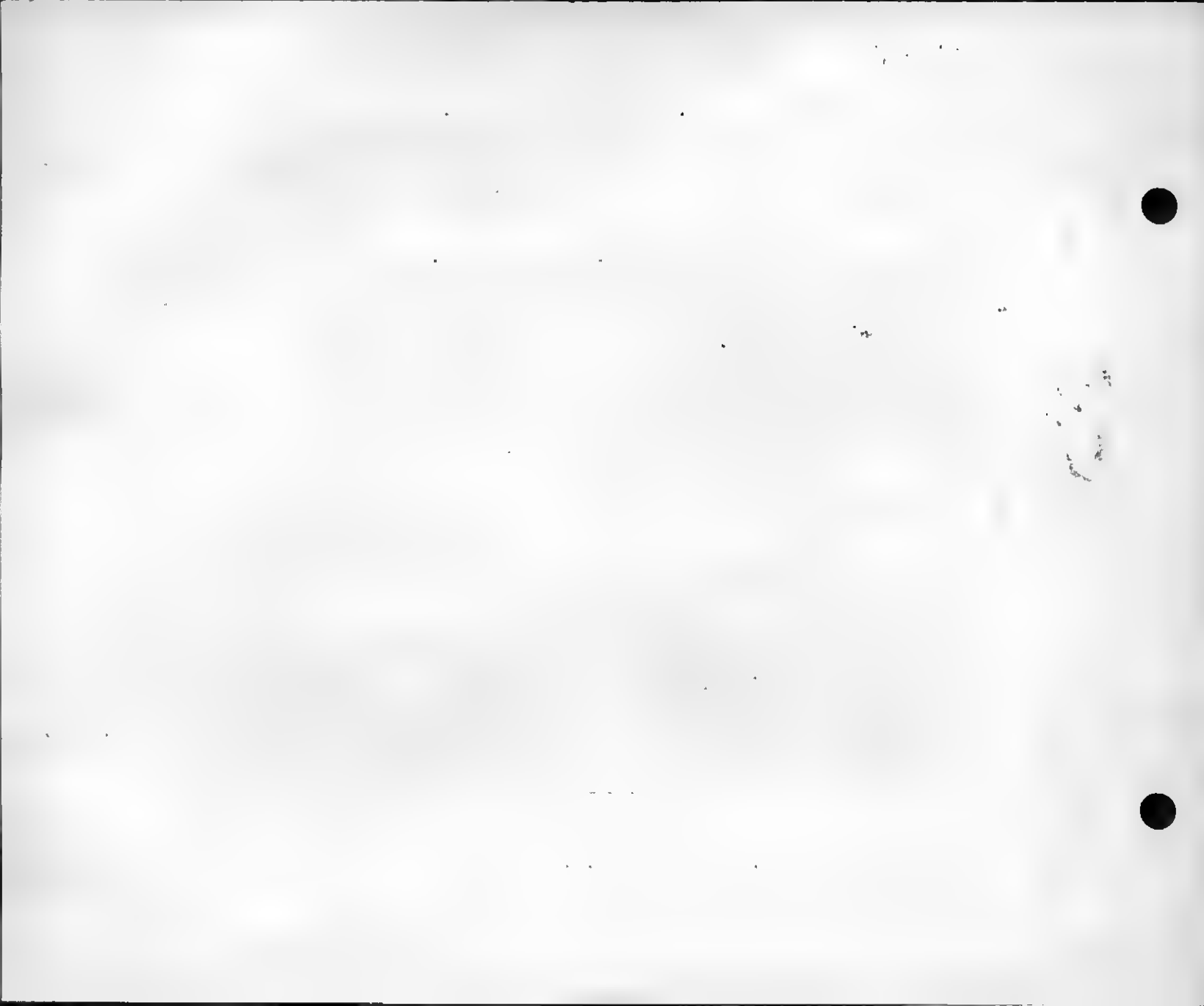
15610

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15620

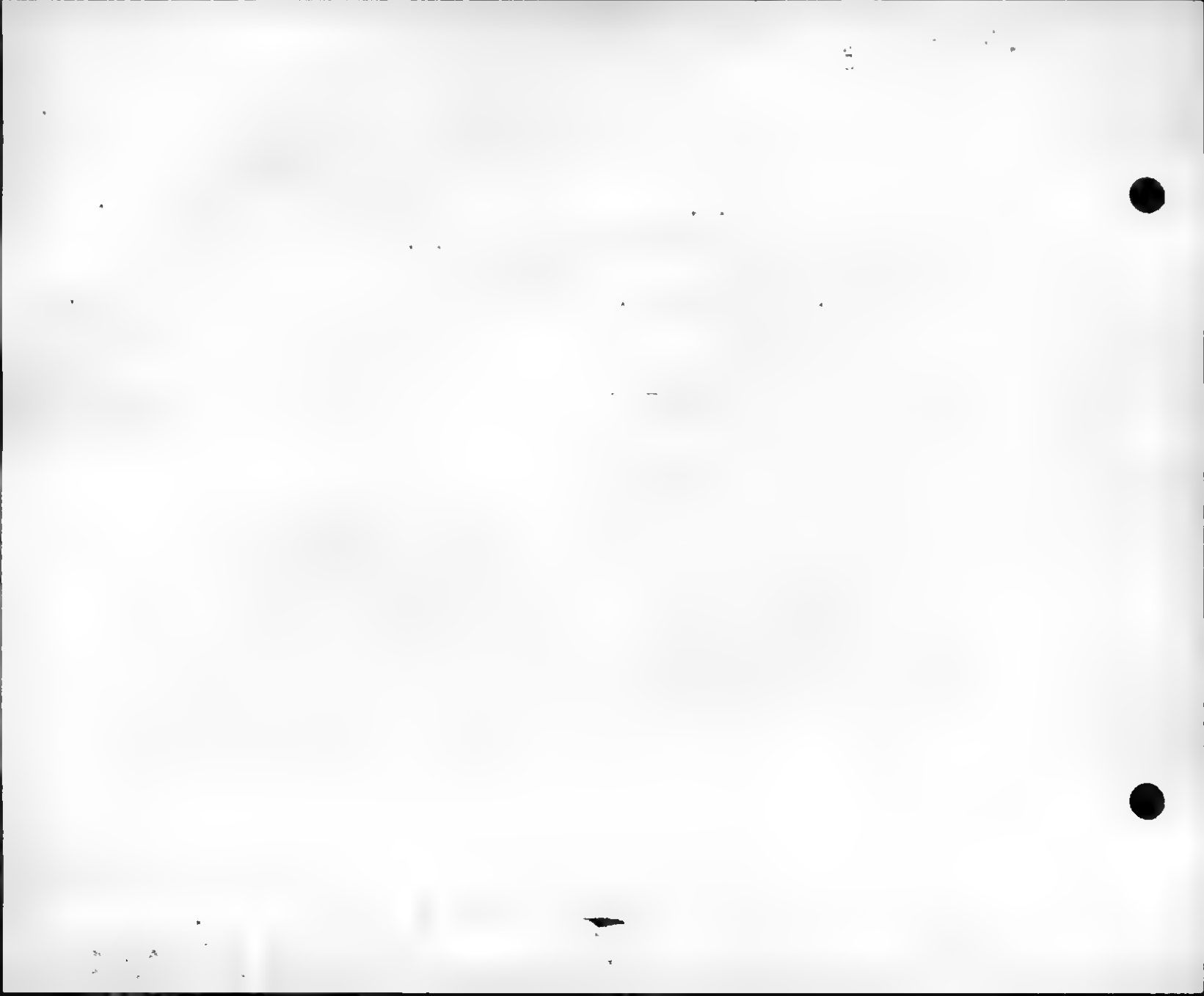
| | | | | | | | | | |
|--|------------------------|---|---|---|---------------------------------------|---|---|---|---|
| 1 DECEASED NAME (Type or Print) CHARLES A. MERRYMAN, Jr. | | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 11-16 1968 | | | 2b HOUR M | | | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH Nov. 30, 1917 | 6 AGE (In years last birthday) 50 YRS | IF UNDER 1 YEAR MONTHS 0 | DAYS 0 | IF UNDER 24 HRS HOURS 0 | MIN 0 | 2c DATE PRONOUNCED DEAD Month 11 Day 16 Year 1968 | 2d HOUR 2:35 AM |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | Md |
| 10 CITY OR TOWN OF DEATH TOWSON | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Josephs Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) PLATER | | 12b KIND OF BUSINESS OR INDUSTRY DENDIX RADIO | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Timonium | | 13d INSIDE CITY LIM 15? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e STREET AND NUMBER 10 Samwill Ave. |
| 14 FATHER'S NAME CHARLES MERRYMAN | | | 15. MOTHER'S MAIDEN NAME DORA STAINES | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16b SOCIAL SECURITY NO 218-18-2318 | | 17 INFORMANT Family Records | | | ADDRESS | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrocranial injuries 8150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8194 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A M 2:00 11-16 1968 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car which hit guardrail then pole | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway | | 21f LOCATION (Street or R.F.D. No.) Route 695 2000 feet east of rte 542 | | City or Town Balt. | | County Md. | State |
| 22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Charles S. Springate | | | M.D. Charles S. Springate, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED 11-16-68 | |
| EXAMINER'S NAME (Type) | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE Nov. 20, 1968 | | 23c NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery | | 23d LOCATION (City or Town) Timonium, Maryland | | (County) (State) | |
| 24 FUNERAL DIRECTOR John Burnie Sons, Towson, Md. | | | | ADDRESS | | 25 REC'D BY REGISTRAR DATE NOV 21 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

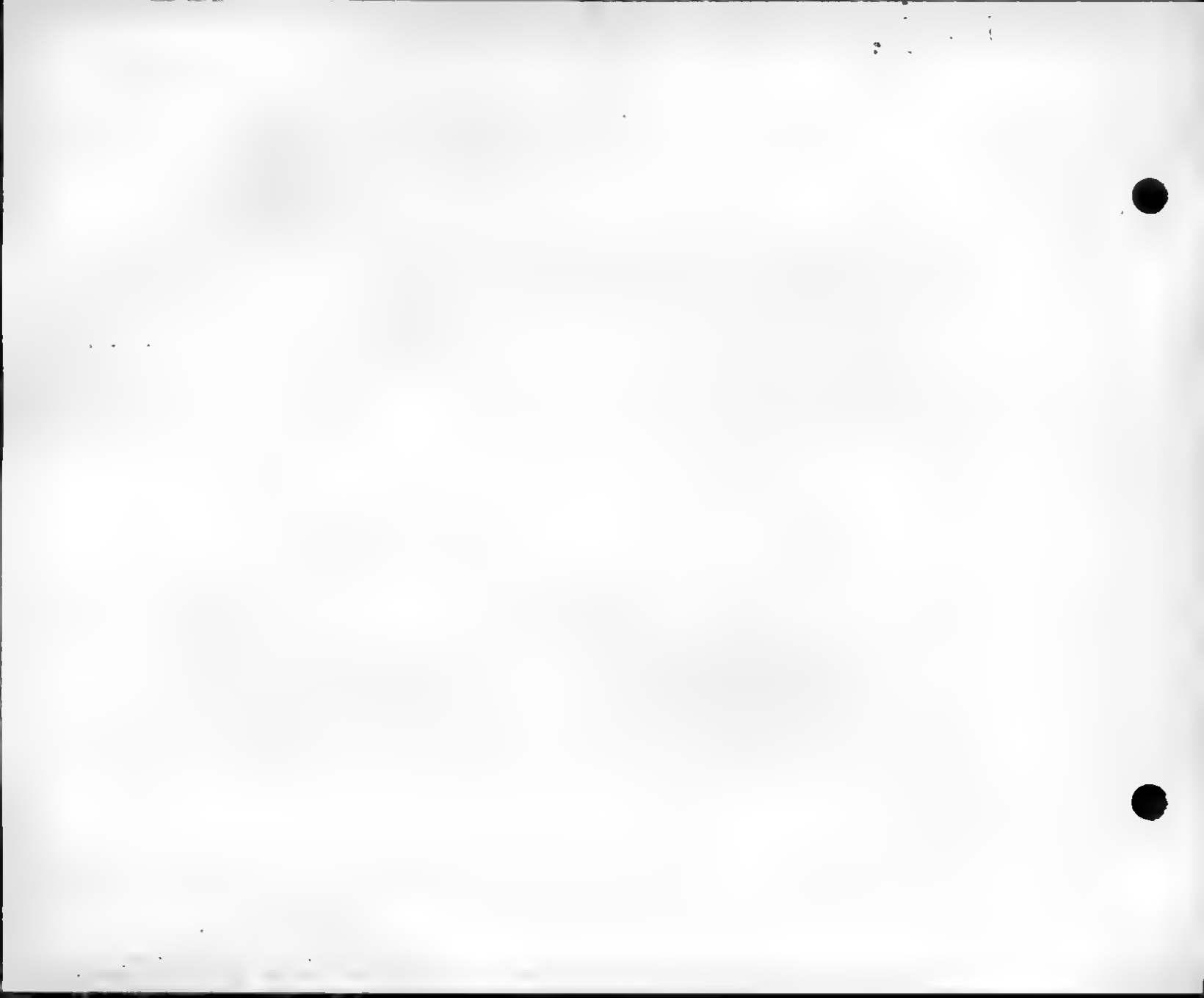
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|---|-------|---|--------|---|------|---|--------------------------|--------------------------------------|----------|------------------|--|----------|--|------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | |
| Anna | | | - | | Meyer | | | | 11 Month 2 Day 68 Year | | A. M. | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| Female | | White | | 2-9-83 | | | | 85 YRS. | | MONTHS | | DAYS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | U.S. | | | | Baltimore Co. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore, 21228 | | | | 228 Harlem Lane | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | |
| Md. | | | | Balto. | | Catonsville | | NO <input checked="" type="checkbox"/> | | 610 Wallerson Rd. 28 | | | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | | Middle | | Last | |
| John | | | | | Meyer | | | | Barbara | | | | | Hildwein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | Address | | | | | |
| NO | | | | 212-54-9956 | | | | Catonsville | | | | 329 Harlem Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | | | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) ACHD | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at home <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased, from 7/3, 1968, to 8/28, 1968, that (I) (we) lost saw the deceased alive on 8/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | |
| J. DAVID NAGEL M.D. | | | | | | | | | | | | 10-2-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | | | |
| J. DAVID NAGEL M.D. | | | | 812 MOCKINGBIRD LANE | | | | Baltimore MD 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | | | |
| Cremation | | 11/5/68 | | Lough Park Cemetery | | Baltimore, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Witzke, 4101 Edmondson Avenue. 21229 | | | | | | | | DATE NOV 7 1968 | | John Charles Judge | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove funeral papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

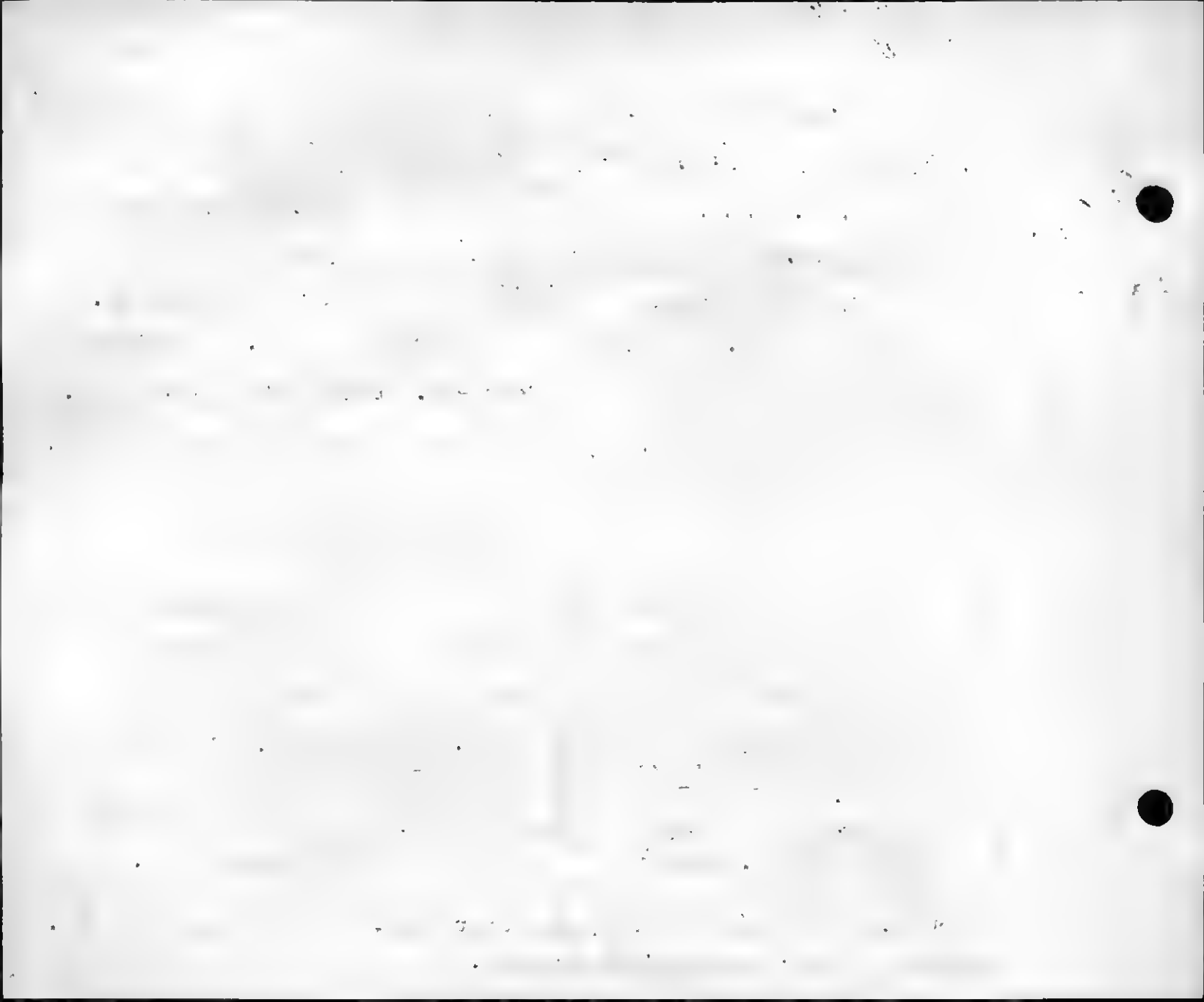
| | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| Item 6 Film 406 11/12/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15618 CERTIFICATE OF DEATH Item 23 per telex call from TEL 11/12/68 15651 | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Edgar | | | | L. Micheau | | | | 11-6 Month Day Year | | | | 68 4:19 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (n years last birthday) | | 7. UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| male | | white | | EPR. 28 1885 | | | | 83 1/2 YRS. | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Maryland | | | | USA | | | | | | | | Baltimore Md | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville, Md. | | | | Summit Nursing Home | | | | Salesman | | | | Appliances | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | K Baltimore | | | | YES | | NO | | Cathedral & Madison St. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO | | | |
| John Micheau | | | | Catherine Kate Prem | | | | 110 | | | | 213-09-1529 | | | |
| 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| Natharine S. Losey 627 E. 34 Street 21218 | | | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage of the bladder</u> | | | | | | | | | | | |
| | | | | (b) <u>fracture</u> | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 111 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | | | 21c. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1968, to 11/6, 1968, that (I) (we) last saw the deceased alive on 11/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| E. KASATIS, M.D. | | | | 11/6/68 | | | | E. KASATIS, M.D. | | | | 1801 Federal Rd Balto. Md. | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | | | 11/11/1968 | | | | Greenmount Cemetery | | | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Eugenia K. Seitz 5209 York Rd Balto. Md. 21212 | | | | DATE NOV 8 1968 | | | | J. Charles Judge | | | | | | | |
| Seitz Funeral Home | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|--------|---|------|--|--|----|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR |
| ANNA | | | L | | MILLER | | 11 | | | 18 | | 9:29 AM |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | | WHITE | | | 9-24-1885 | | | 83 | | MONTHS | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore, Md. | | | U.S.A. | | | | | | BALTIMORE | | | Md. |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| TOWSON | | | CHESAPEAKE MANUFACTURING CO. | | | homemaker | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER |
| Md. | | | Balto. | | | Rogers Forge | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 324 Overbrook Rd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Joseph | | | Mary | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | |
| No | | | | | | George N. Miller | | | 324 Overbrook Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | 10 yrs. | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | City or Town County State | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 1967, to Nov. 18, 1968, that (I) (we) last saw the deceased alive on Nov. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | 22c. DATE SIGNED | | | |
| Lloyd E. Saylor, M.D. | | | | | | | | | 11/19/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | |
| Lloyd E. Saylor | | | | | | 3902 Greenmount Ave. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 11/21/ 1968 | | | Holy Redeemer Cent. | | | Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Mitchell Wiedefeld Home | | | | | | 6500 York Rd. | | | DATE NOV 25 1968 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 7-65

| <div> <div>Item 5 Film 406 11/13/68 125</div> <div>15620</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15620</div> </div> | | | | | | | | | | |
|--|--|--|---|--|--|---|--|-----------------------------|--|--|
| 1. DECEASED-NAME (Type or print) <i>George B. C. Miller, Sr.</i> | | | | | 2a. DATE OF DEATH <i>Nov. 1, 1968</i> | | | 2b. HOUR <i>M</i> | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>Nov. 24, 1897</i> | | 6. AGE (in years last birthday) <i>71</i> YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore Co.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Ridge Rd.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Bu. of Recpt.</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Hebbville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>7339 Windsor Mill Rd.</i> | |
| 14. FATHER'S NAME First Middle Last <i>George B.C. Miller</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i> (If yes give year or dates of service) <i>WW 1</i> | | | 16b. SOCIAL SECURITY NO. <i>214-40-4612</i> | | 17. INFORMANT Address <i>Mrs. Ella E. Miller-7339 Windsor Mill Rd.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Uropathy - Prostatic Hypertrophy -</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>610X</i> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized Arteriosclerosis - Chronic Brain Syndrome</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-21-1968</i> , to <i>11-1-1968</i> , that (I) (we) last saw the deceased alive on <i>11-1-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Cesar Valle Cervero</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED <i>11-2-68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>CESAR VALLE CAVERO</i> | | | | | 22e. ADDRESS <i>8629 Liberty Rd.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Nov. 5, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Randallstown Balto Md.</i> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>John T. Stansbury, SR-6411 Windsor Mill RD.</i> | | | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 4 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>f Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)
30M REV 1/68

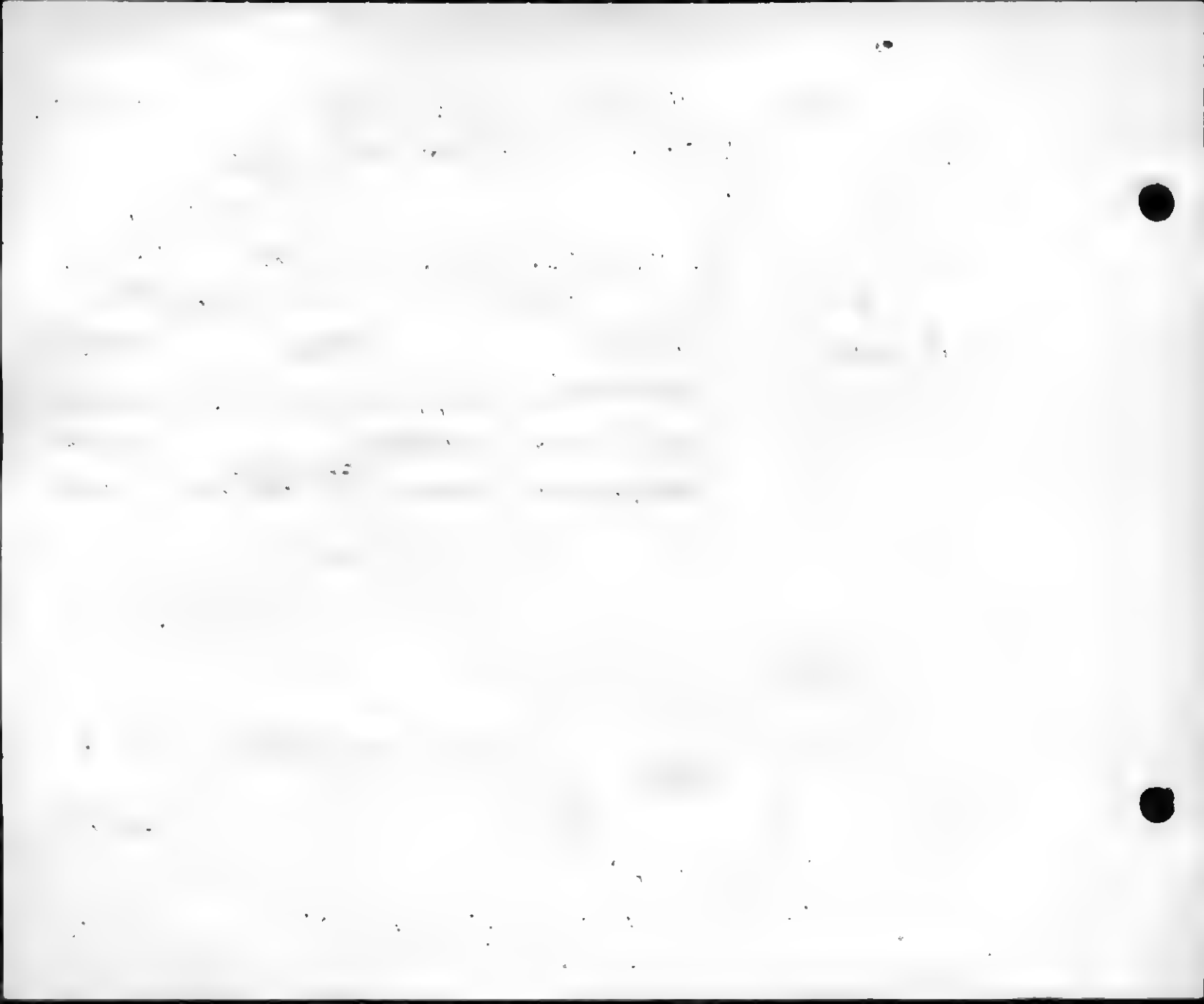
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15621

15621

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) HARRY HUSTON MILLER | | | 2a. DATE OF DEATH Nov Month 5 Day 1968 | | 2b. HOUR 6:30 A.M. |
| 3. SEX MALE | 4. RACE NEGRO | 5. DATE OF BIRTH 23 Nov 1919 | | 6. AGE (In years lost birthday) 48 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) VA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County, Md | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 1856 N. GAY ST. |
| 14. FATHER'S NAME First NORMAN Middle MILLER Last MILLER | | 15. MOTHER'S MAIDEN NAME First MARY Middle CARTER Last CARTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 246-48-0385 | | 17. INFORMANT Address Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FIBROSIS DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY TUBERCULOSIS, QUIESCENT, FAR ADV. DUE TO, OR AS A CONSEQUENCE OF (c) 3 YEARS Approximate interval between onset and death 3 YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that the (this hospital) attended the deceased from 17 JULY, 19 68 to 5 Nov , 19 68 , that we (we) lost the (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE William Newcomer DEGREE MD | | | | 22c. DATE SIGNED 5 Nov 1968 | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | 22e. ADDRESS Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 11/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Wilson Cemetery | |
| 23d. LOCATION (City or Town) BALTIMORE | | 23e. LOCATION (County) BALTIMORE | | 23f. LOCATION (State) MD | |
| 24. FUNERAL DIRECTOR DONALD E. GLOVER | | 25a. REC'D BY REGISTRAR NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

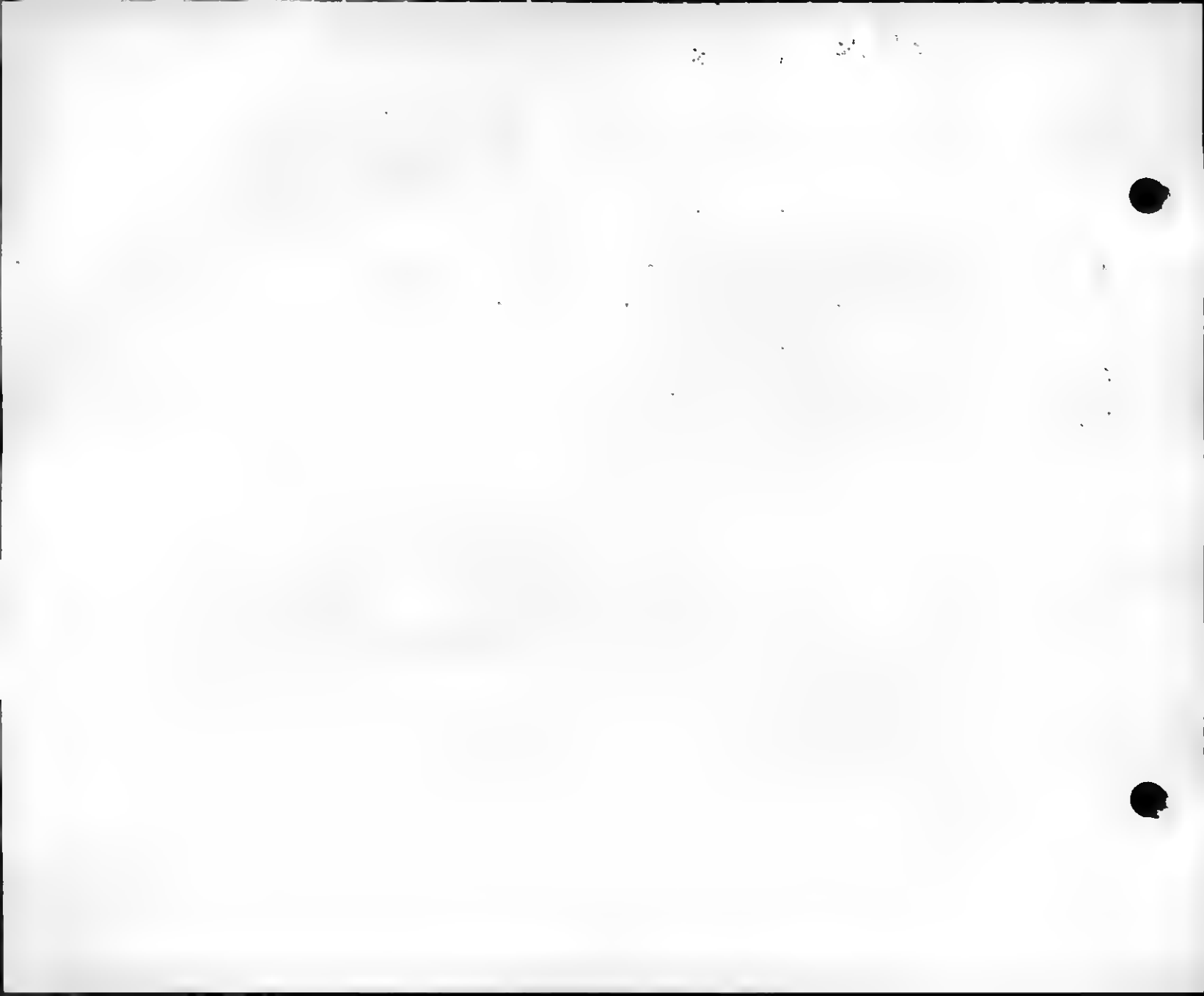
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15635

| | | | | | | | | | |
|--|------------------------------|---|--|---|-----------------------------------|--|---|---|--|
| 1 DECEASED NAME (Type or print) | | First | Middle | Last | 2a DATE OF DEATH | | 2b. HOUR | | |
| LAWRENCE L | | | MINGHINI | SR. | 11 Month 12 Day 68 Year | | 6:35 PM | | |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| MALE | CAUCASIAN | | 8/28/09 | | 59 YRS. | | | | |
| 7a BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | |
| Ridgely, W.Va. | U.S. | | | | BALTIMORE | | Md. | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | GREAT. BALT. MED. CENT | | Chauffer- | | A.S. Abell Co. | | | |
| 13a USUAL RESIDENCE (Where deceased admission) STATE | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Md. | | Balto. | | Balto. | | | | 4429 Shamrock Ave. | |
| 14 FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Paul J. Minghini | | | | Lillian McCoy | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | |
| yes | | 216-05-9309 | | Naomi Ray Minghini, wife, above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | | | | | | | | |
| 16d1 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) CARCINOMA OF LUNG WITH METASTASIS TO | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF CEREBRAL SPINE | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 11 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/4, 1968, to 11/12, 1968, that (I) (we) last saw the deceased alive on 11/12 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | | 22c DATE SIGNED | | | |
| C. Lin, M.D. | | | | | | 11/12/68 | | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e ADDRESS | | | | | | | |
| C LIN, M.D. | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/15/68 | | Baltimore National Cem. Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Schinunek Funeral Home, Inc. 3331 Brehms Lane | | | | DATE NOV 18 1968 | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

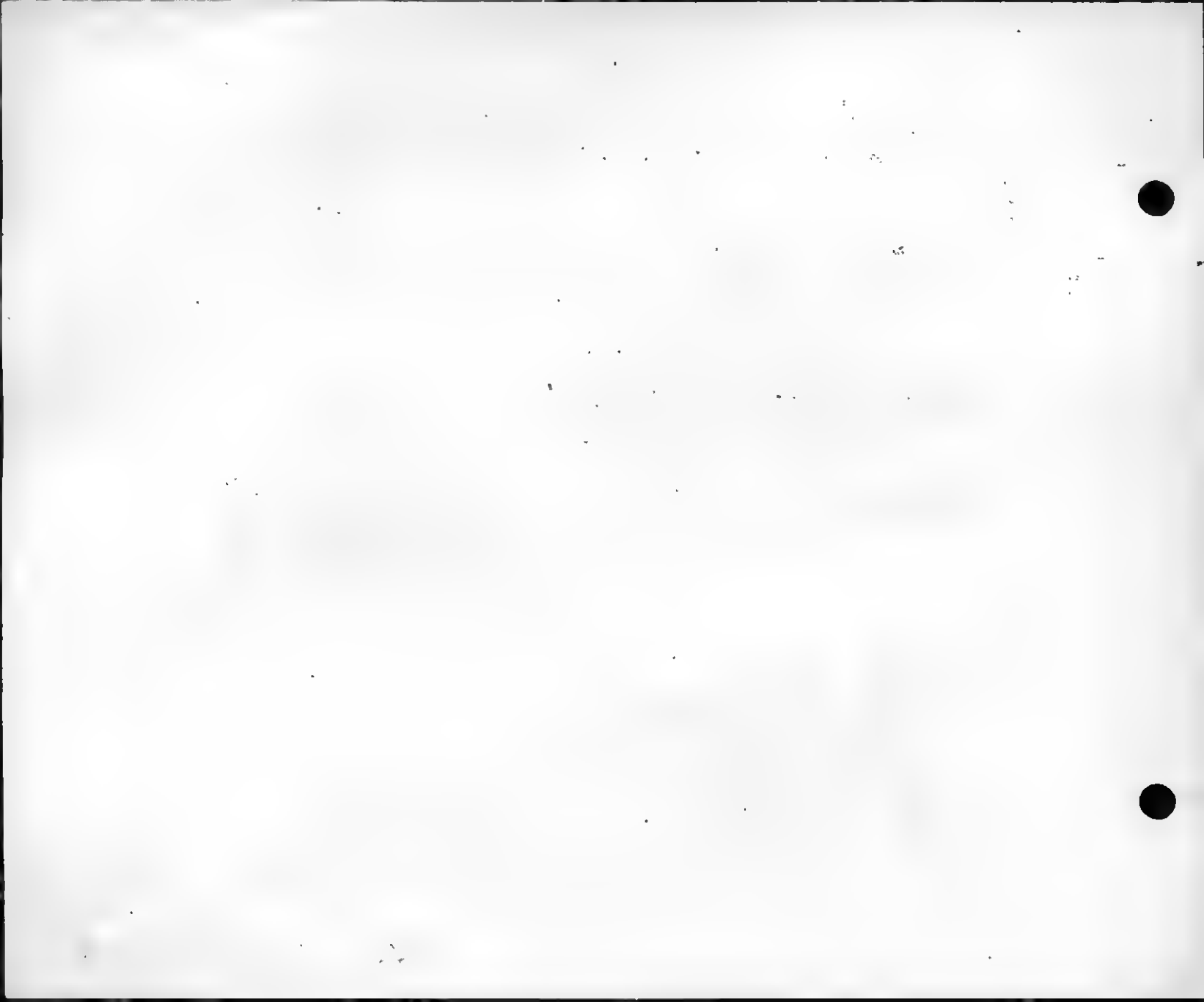
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15623

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15623

| | | | | | | | |
|--|----------------------------|---|--|---|--|---|------------------------|
| 1 DECEASED NAME (Type or Print) First Middle Last HUMBERT (MIDDLE) MONTANARI | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 11-27-1968 | | | 2b HOUR 5 AM | |
| 3 SEX MALE | 4 RACE CAUCASIAN | 5 DATE OF BIRTH APR. 9, 1885 | 6 AGE (in years last birthday) 83 YRS | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | 2c DATE PRONOUNCED DEAD Month Day Year 11-27-1968 | | 2d HOUR 6 AM |
| 7a BIRTHPLACE (State or foreign country) ITALY | | 7b CITIZEN OF WHAT COUNTRY? ITALY | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH BALTIMORE | |
| 10 CITY OR TOWN OF DEATH DUNDALK | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 245 RIVERVIEW AVE | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER | | 12b KIND OF BUSINESS OR INDUSTRY STEEL MFG. | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN DUNDALK | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e STREET AND NUMBER 245 RIVERVIEW AVE | | 14. FATHER'S NAME First Middle Last (?) MONTANARI | | 15. MOTHER'S MAIDEN NAME First Middle Last UNK. | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16b SOCIAL SECURITY NO 220-44-2864 | | 17 INFORMANT ROSE MONTANARI | | ADDRESS AS IN #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructed airway DUE TO, OR AS A CONSEQUENCE OF (c) Disease | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE THEODORE C. PATTERSON | | EXAMINER'S NAME (Type) THEODORE C. PATTERSON | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED 11/29/68 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 11/30/1968 | | 23c NAME OF CEMETERY OR CREMATORY OAK LAWN | | 23d LOCATION (City or Town) (County) (State) BALTO. CO., MD | |
| 24 FUNERAL DIRECTOR W. Bruce Bradley, Dundalk, Maryland | | 25a REC'D BY REGISTRAR DATE DEC 2 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OF TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | |
|---|--|---------------------|---|--------------------------------|--|---|---|--|---|-----------------------|--|--|
| Item 1 per telephone call DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Jenkins F.H. 11/20/68 15624 CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) First a/k/a Francis Middle William Last MORAN | | | | | 2a. DATE OF DEATH Month 11 Day 18 Year 68 | | | | | 2b HOUR 6:40AM | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH 5/28/97 | | | 6 AGE (n years last birthday) 71 YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 8 UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign) MASSACHUSETTS | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH BALTIMORE COUNTY | | | |
| 10 CITY OR TOWN OF DEATH FORT HOWARD | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADMINISTRATION HOSPITAL | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN | | | 12b KIND OF BUSINESS OR INDUSTRY Shoe | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE MARYLAND | | | 13b COUNTY | | | 13c CITY OR TOWN BALTIMORE | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e STREET AND NUMBER 5004 ROLAND AVENUE | | | 14 FATHER'S NAME First MYLES Middle Last MORAN | | | 15. MOTHER'S MAIDEN NAME First CATHERINE Middle Last CARTER | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, up to (known) YES (If yes, give war and dates of service) WW II | | | |
| 16b. SOCIAL SECURITY NO 474 09 84 15 | | | 17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | RECENT | | | |
| (b) PULMONARY CONGESTION AND EDEMA | | | RECENT | | | (c) PEPTIC ULCER, DUODENUM | | | RECENT | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA LEFT LUNG WITH METASTASIS TO RIGHT LUNG & LIVER. ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Hot while at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 9/29/68 , 19____, to 11/18/68 , 19____, that (X) (we) last saw the deceased alive on 11/18/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Subramanian | | | 22c. DATE SIGNED 11/18/68 | | | 22d PHYSICIAN'S NAME (Type) KRISHNA V. S. RAO, M. D. | | | | | | |
| 22e ADDRESS VAH FORT HOWARD, MARYLAND | | | 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | |
| 23b DATE 11/20/68 | | | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | | 23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | 24. FUNERAL DIRECTOR HENRY W. JENKINS FUNERAL HOME | | | |
| 24b ADDRESS 1905 York Road, Baltimore, Md. | | | 24c REGISTRATION NO. 1568 | | | 24d REGISTRAR'S SIGNATURE | | | 24e REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 1
304A REV 1768

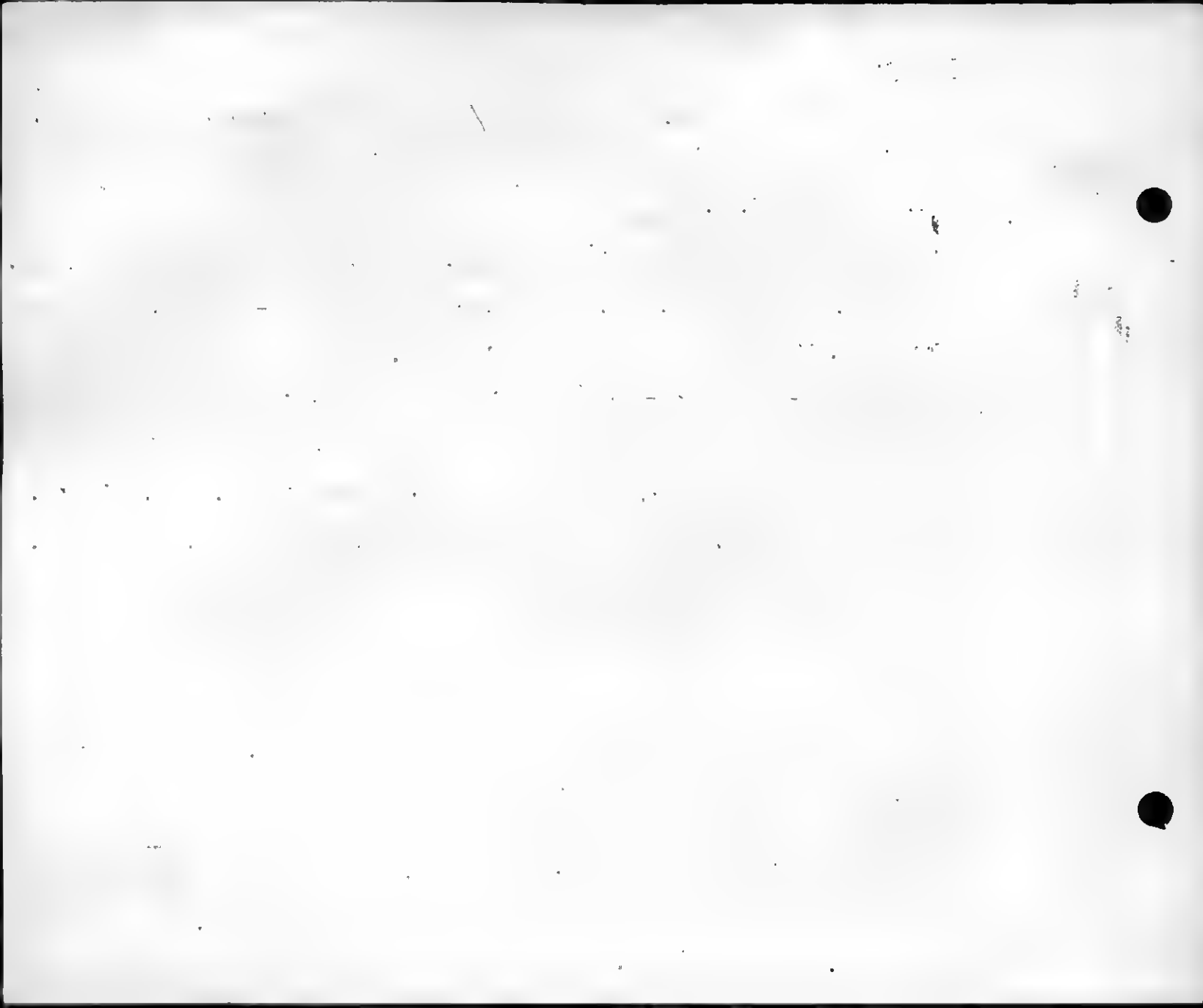
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15625

15625

CERTIFICATE OF DEATH

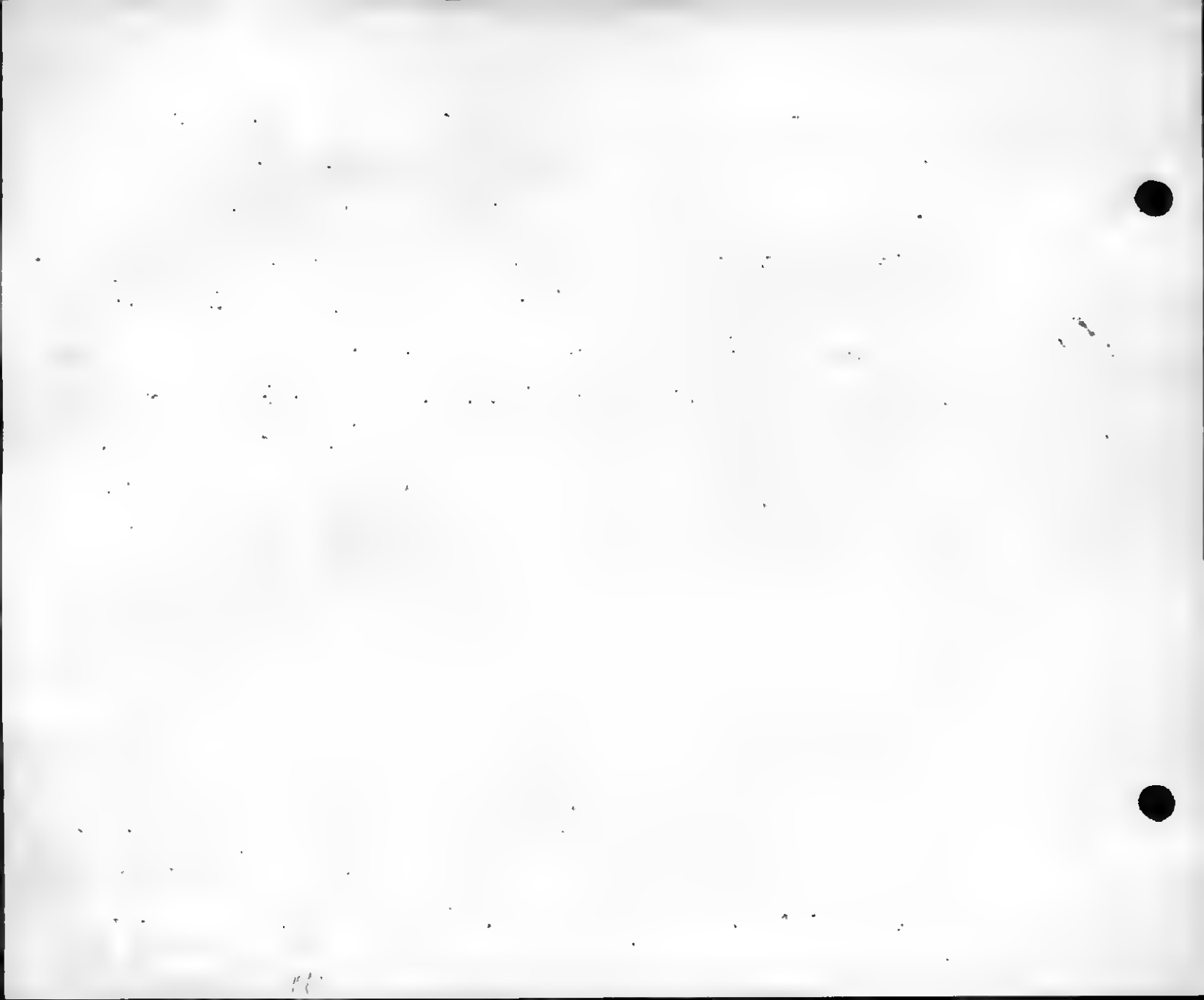
| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (Type or print) Hassell Pittman | | First Middle MOYER Moyers | | 2a DATE OF DEATH Month November Day 13 Year 1968 | | 2b HOUR 5:55 a. M | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH May 26, 1905 | | 6 AGE (In years last birthday) 63 YRS | |
| 7a BIRTHPLACE (State or foreign country) Va. | | 7b CITIZEN OF WHAT COUNTRY? U. S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md | |
| 10 CITY OR TOWN OF DEATH Catonsville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP. | | 12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) File Clerk | | 12b KIND OF BUSINESS OR INDUSTRY U.S. Govt. | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b COUNTY Pr. Geo. Mt. Rainier | | 13c CITY OR TOWN File Clerk | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME First Frank L. Moyer | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME First Fanny E. ? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 224-16-8102 | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death, DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic, Cardiovascular Ht. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, Senile. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 10 yrs. 10 yrs. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that the (this hospital) attended the deceased from June 17 , 19 68 , to Nov. 13 , 19 68 , that it (we) last saw the deceased alive on Nov. 13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Anthony J. Young, M.D. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c DATE SIGNED 11-13-68 | |
| 22d PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | | 22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 11-16-68 | | 23b DATE 11/16/68 | | 23c NAME OF CEMETERY OR CREMATORY Geo. Wash. Cen. | | 23d. LOCATION (City or Town) (County) (State) Hyattsville, Md. | |
| 24. FUNERAL DIRECTOR Valley's Funeral Home Inc | | | | ADDRESS Mt. Rainie Md. | | 25a. REC'D BY REGISTRAR DATE NOV 19 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Young | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>Item 13 Film 407 12/12/68</div> <div>15026</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15640</div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (Type or print) <i>Clifton</i> | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year <i>11-29-68</i> | | | 2b. HOUR <i>6:25 PM</i> | | |
| 3. SEX <i>male</i> | | | 4. RACE <i>Colored</i> | | | 5. DATE OF BIRTH <i>9-30-1912</i> | | | 6. AGE (In years last birthday) <i>56</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Crown Co., Ga.</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Baltimore Co.</i> | | |
| 10. CITY OR TOWN OF DEATH <i>Reisterstown, Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Best Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>At home</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Reisterstown</i> | | | 13c. CITY OR TOWN <i>Reisterstown</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last <i>John H. Murphy</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Lizzie Maye</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. <i>21747-0653</i> | | |
| 17. INFORMANT <i>Mrs. Mary Sutton</i> | | | Address <i>1735 Pulaski Street</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 1120 DUE TO, OR AS A CONSEQUENCE OF (b) <i>degenerative CV Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Approximate interval between onset and death <i>3 hours</i> <i>9 years</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-4</i> , 19 <i>67</i> , to <i>11-29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>11-29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>C. E. McWilliams</i> | | | 22c. DATE SIGNED <i>11-29-68</i> | | | 22d. PHYSICIAN'S NAME (Type) <i>Reisterstown Maryland 21136</i> | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE <i>12-4-68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. PK.</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Arbutus Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>Collick Fun. Hm.</i> | | | 24b. ADDRESS <i>2431 E. Diver Street</i> | | | 25a. RECEIVED BY REGISTRAR <i>DEC 5 1968</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



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| | | | | | |
|--|-------------------------------------|---|--|---|--|
| 15627 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 15641 | |
| Items #13b, c, e Film #G407 12/4/68 | | | | | |
| 1. DECEASED NAME (Type or print) First Middle Last Mary Madeline Murphy | | | 2a. DATE OF DEATH 11 Month 25 Day 68 Year | | 2b. HOUR 11:12 P.M. |
| 3. SEX Female | 4. RACE Cau | 5. DATE OF BIRTH June 4, 1892 | | 6. AGE (In years last birthday) 76 YRS. | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Balto. Med. Center | | 12a. JSUA. OCCUPATION (Kind of work done during most of working life, even if retired) At Home | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md. | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN SevernaPk. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Box 576A, Rt. #2 |
| 14. FATHER'S NAME First Middle Last John J. Houff | | | 15. MOTHER'S MAIDEN NAME First Middle Last Katherine E. Tobin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO 220-14-9507 | | 17. INFORMANT Family records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe coronary atherosclerosis 4127 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/13, 1968, to 11/25, 1968, that (I) (we) lost the deceased alive on 11/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles C. Brown, M.D. | | | | 22c. DATE SIGNED 11/26/68 | |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D. | | | | 22e. ADDRESS 6701 N. Charles Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem | |
| 23d. LOCATION (City or Town) Frederick, Frederick Md | | 23e. LOCATION (County) Frederick | | 23f. LOCATION (State) Md | |
| 24. FUNERAL DIRECTOR Chas. F. Evans & Son | | ADDRESS 8802 Harford Rd | | 25a. REC'D BY REGISTRAR DATE DEC 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



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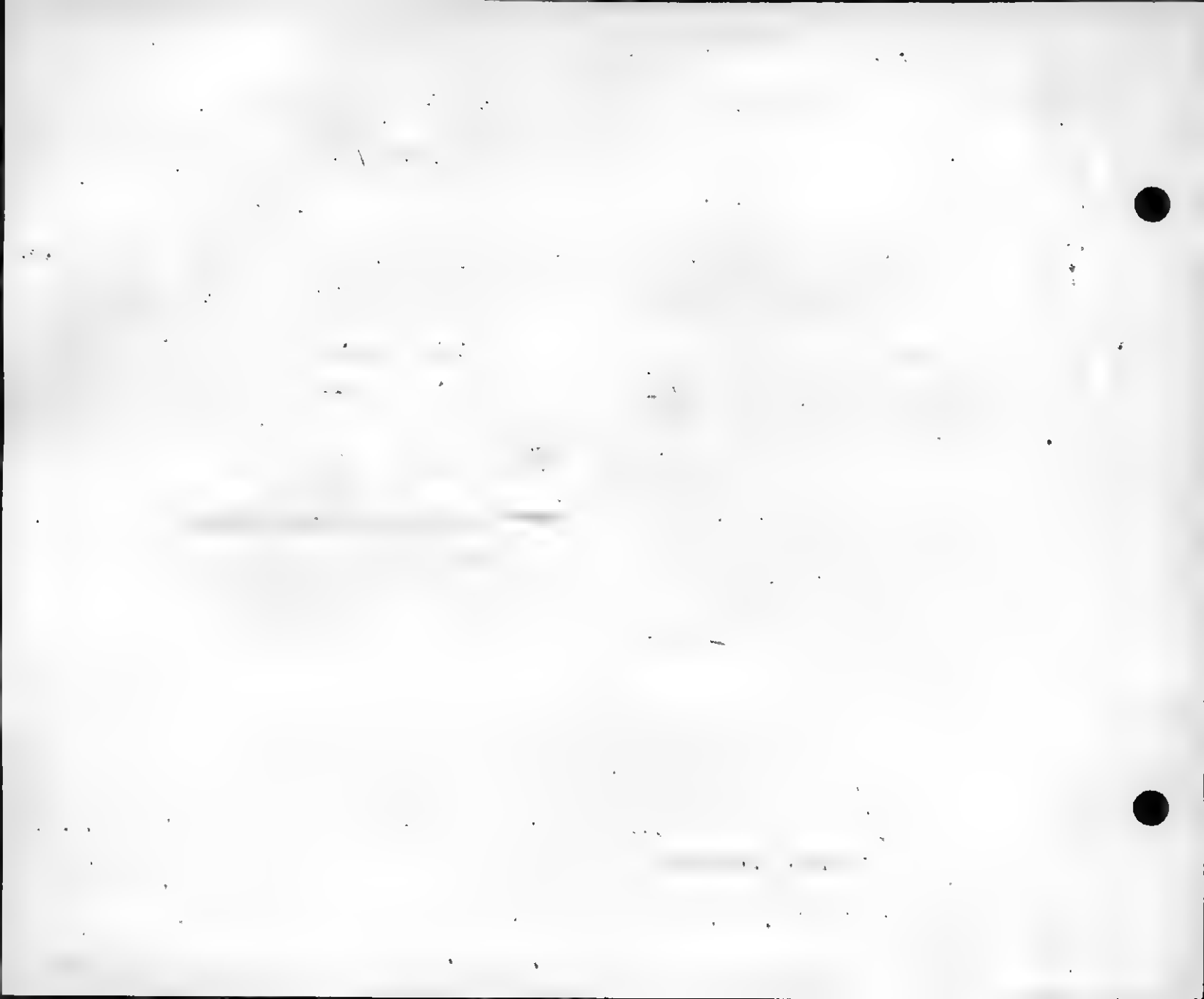
| | | | | | |
|---|------------------|---|--|--|--|
| 15628 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 15642 | |
| It rs#7a b , Filr#06 11/22/68 km | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (Type or print) John A. Muse | | | 2a. DATE OF DEATH Month 11 Day 10 Year 1968 | | 2b. HO. JR. 6A |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 7/20/91 | | 6. AGE (In years last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS 77 DAYS 77 |
| 7a. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Baltimore | | Md | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit M.H. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WATCHMAN | |
| 12b. KIND OF BUSINESS OR INDUSTRY HOUSING CO. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 700 Yale Ave. | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. (27) | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 700 Yale Ave. | | | |
| 14. FATHER'S NAME First JOHN Middle MUSE Last MUSE | | | 15. MOTHER'S MAIDEN NAME First BARBARA Middle MICHAELS Last MICHAELS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO. 216-65-4518 | | 17. INFORMANT Mrs. John A. Muse - 700 Yale Ave. | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSECTROTIC CARDIOVASCULAT DUE TO, OR AS A CONSEQUENCE OF Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4-2-1 (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS + | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or RFD No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1966 , to 7/10, 1968 , that (I) (we) last saw the deceased alive on 11/10/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE Thos. E. Roach M.D. DEGREE MD | | 22c. DATE SIGNED 11/11/68 | | 22d. PHYSICIAN'S NAME (Type) Thos. E. Roach M.D. | |
| 22e. ADDRESS 5550 Bedford Ave. Pk 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem | |
| 23d. LOCATION (City or Town) Baltimore | | (County) Md. | | (State) Md. | |
| 24. FUNERAL DIRECTOR Foley-Cronan & Co. Catonsville | | ADDRESS | | 25a. REC'D BY REGISTRAR NOV 14 1968 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|-------|--|
| Item 5 Film 406 11/7/68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH | | | | | | | | | | 15643 | | | | | |
| 1. DECEASED NAME (Type or print) | | | | First Middle Last | | 20. DATE OF DEATH | | | | 2b. HOUR P.M. | | | | | |
| Gertrude | | | | - | | Nase | | | | November 1, 1968 | | | | 3:12 | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | White | | 2-10-1987 | | | | 81 | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Pa. | | USA | | | | Baltimore | | | | Own Home | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | | |
| Baltimore | | | | St. Joseph Hospital | | | | Homemaker | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY, J.M.T.S? | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | | | Baltimore | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 24 Northampton Rd. #21093 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John Stull | | | | Alice Leipter | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | |
| No | | | | None | | 2154 | | | | Family information | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> | | | | | | | | | | | | | | | |
| DUE TO <u>vascular thrombosis of right</u> | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) <u>ovarian cyst.</u> | | | | | | | | | | | | | | | |
| stating the underlying cause last <u>uterine leiomyosarcoma</u> | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| <u>Papillary cyst-adenoma, right ovary; Partial intestinal obstruction.</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 16, 1968</u> , to <u>November 1, 1968</u> , that <u>XX</u> (we) last saw the deceased alive on <u>November 1, 1968</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we), (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| <u>Harry J. Connolly, M.D.</u> | | | | November 1, 1968 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | |
| Harry J. Connolly, M.D. | | | | 7620 York Road, Towson, Md. 21204 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Removal | | Nov. 4, 1968 | | Ridge Valley Cemetery | | | | Quakertown, Pa. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| <u>John Bruno</u> | | | | DATE NOV 4 1968 | | | | <u>Charles Judge</u> | | | | | | | |



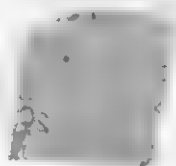
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

| <div>15630</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>15644</div> | | | | | | | | | | | |
|---|--------|--|--------------------------------|---|--|---|--|---|----------------------------------|---------|--|
| 1 DECEASED NAME (Type or Print) | | First Items 18 ~ 2 Middle Film G409 Last 2/25/69 ca | | | | | | 2a DATE KNOWN OF DEATH | | 2b HOUR | |
| FRANK J. NEMETHY | | | | | | | | DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 11 24 1968 | | 1:am | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Male | White | 9/10/48 | 29 YRS | MONTHS DAYS | | HOURS MIN | | Month Day Year | | 1:am | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| Maryland | | U. S. A. | | | | Balto. Md. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Dundalk | | 2609 Yorkway Yorkway Apts. | | | | Sub Shop Work, Capt. Harvey's | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Md. | | Balto. | | Dundalk | | | | 2609 Yorkway Yorkway Apts. | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | | | |
| William Nemethy | | Delores Rossbach | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT (Father) | | ADDRESS | | | | | |
| No | | 212-48-3418 | | Mr. William Nemethy, 6841 Belclare Rd. | | Dundalk, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intravenous narcotism | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | 19 | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | November 24, 1968 | | | |
| Edward F. Wilson, M.D. | | | | DEPUTY MEDICAL EXAMINER | | | | | | | |
| ADDRESS | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 11/27/68 | | Holy Redeemer Cemetery | | Baltimore, Md. | | | | | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | DATE NOV 29 1968 | | | | Charles Judge | | | |



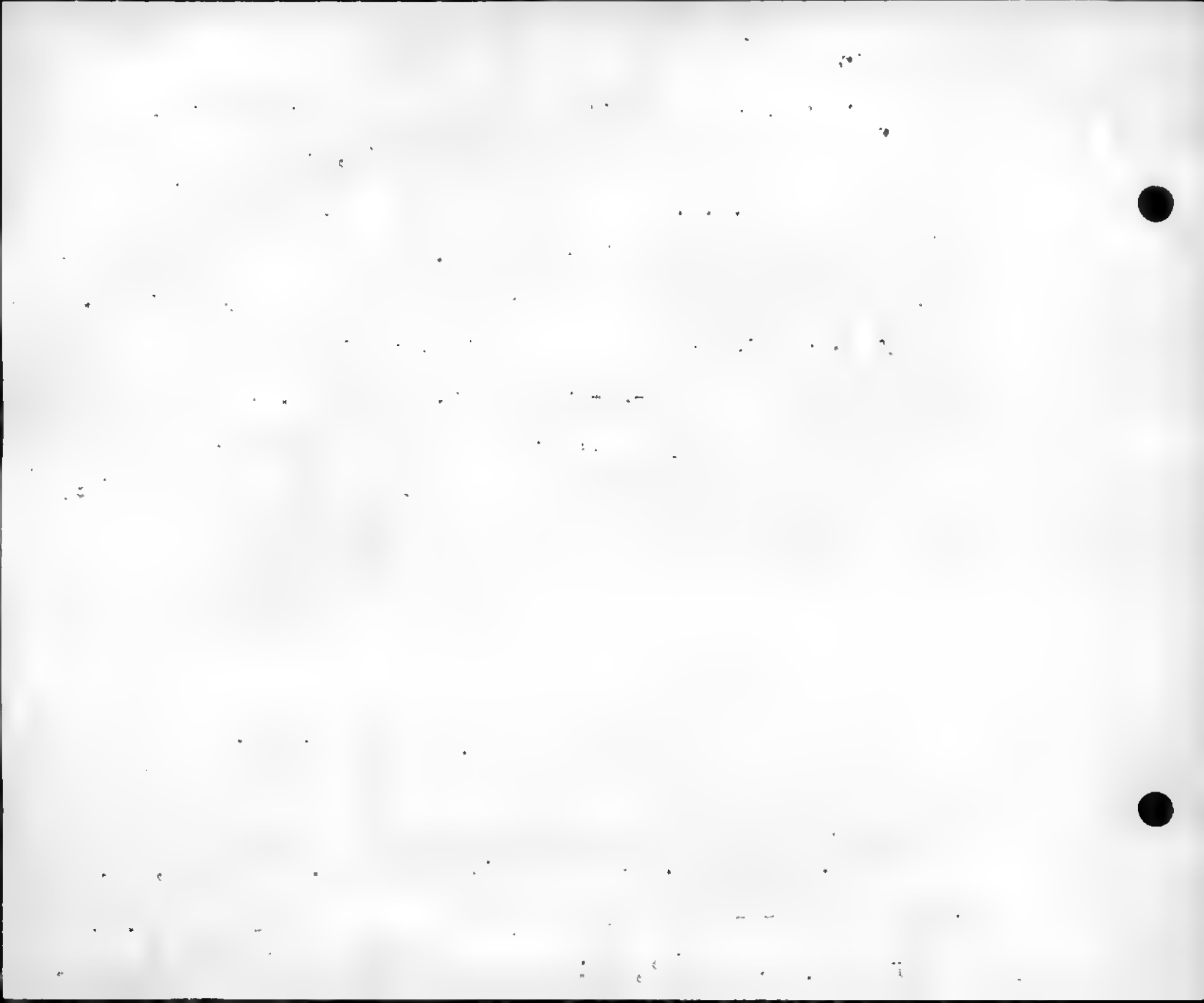
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|------------------------|--|--|---------------------------------|--|
| 15631 | | 15046 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Helen Edna Niedrach | | | | | | 2a. DATE OF DEATH Month Day Year November 8, 1968 | | | 2b. HOUR M | | | |
| 3 SEX Female | | 4. RACE white | | 5. DATE OF BIRTH November 29, 1883 | | | 6. AGE (n years last birthday) 84 YRS. | | 7. UNDER YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Kodgers rorge | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 223 Regester Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY Book Store | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Kodgers rorge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 223 Regester Ave. | | | |
| 14. FATHER'S NAME First Middle Last hugo E. Distelhurst | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances Van Deusen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 214-22-0822 | | 17. INFORMANT Mr. Kenneth C. Kath | | | Address Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 43.1 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC. | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1968 to PXN 1968 , that (I) (we) last saw the deceased alive on Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Charles H. Reier M.D. | | | | | | 22c. DATE SIGNED 9 Nov 68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier | | | | | | 22e. ADDRESS 6701 York Rd. Baltimore, Md. | | | | | | |
| 23a. BURIAL, CREMATION, XXXXXX | | | 23b. DATE 11-9-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Mitchell-wiedefeld Home, Inc. | | | | | | ADDRESS 6000 York Rd. Baltimore, Md. | | | 25a. REC'D BY REGISTRAR NOV 12 1968 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |

MEDICAL CERTIFICATION

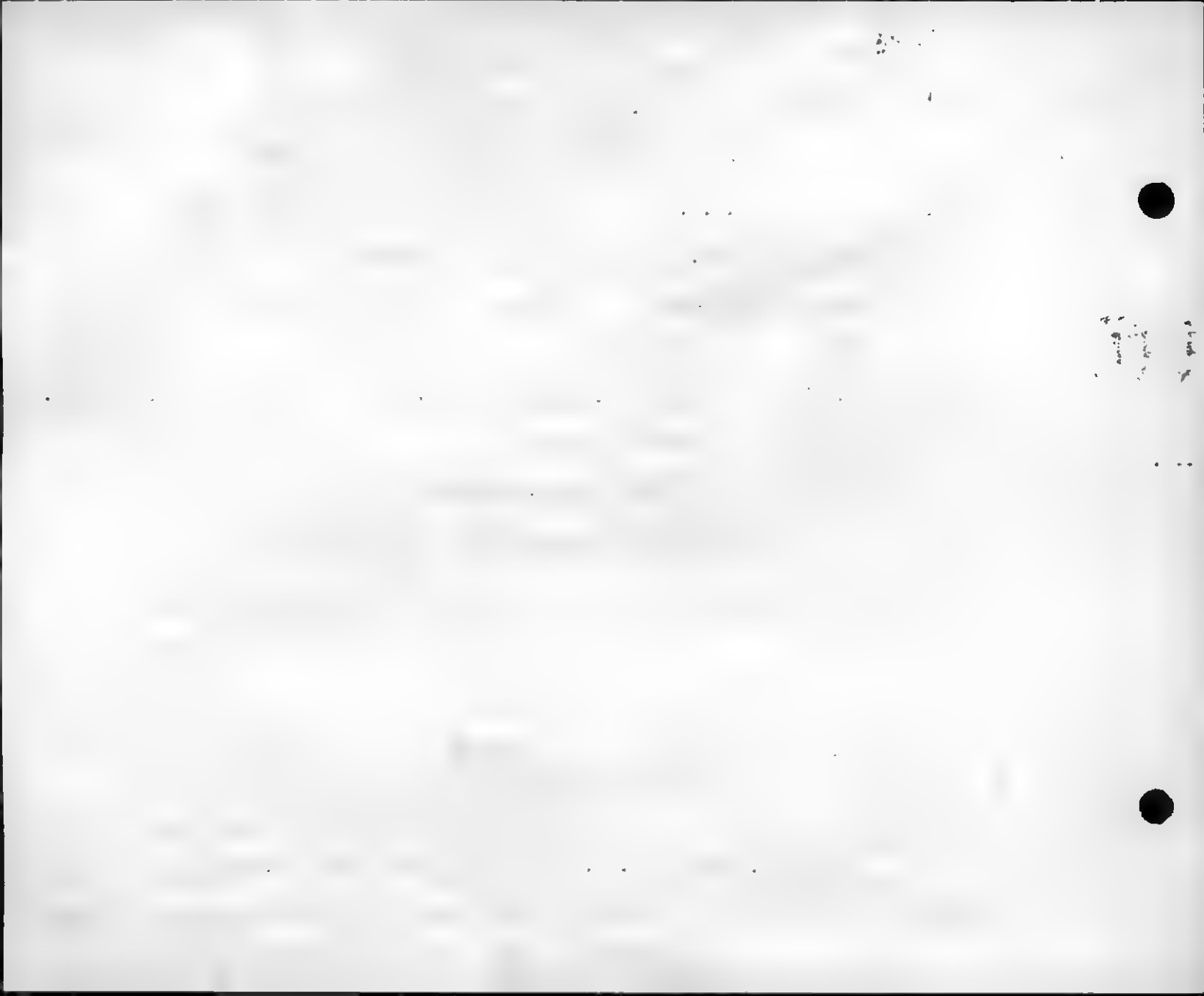


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

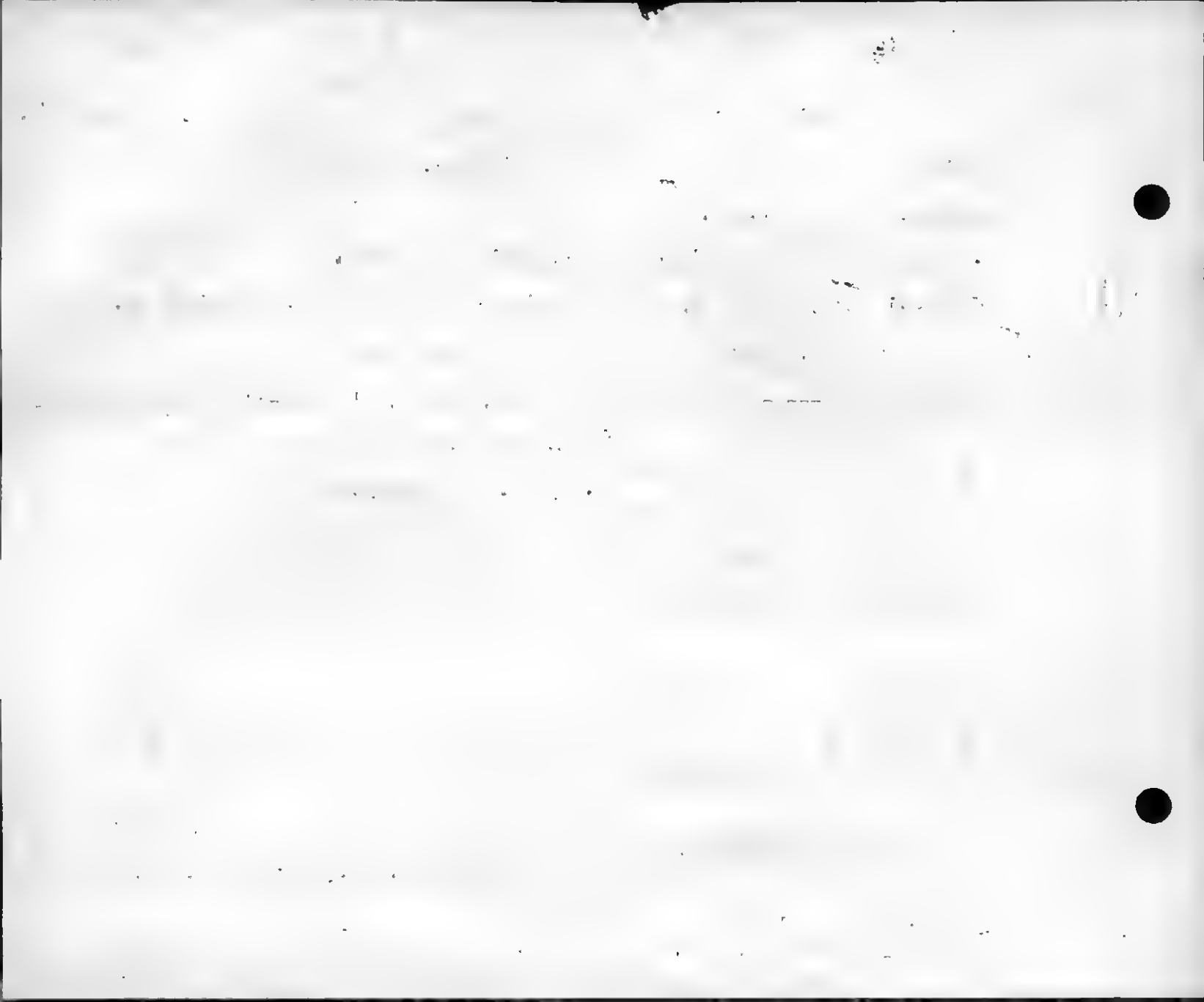
| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH | | 2b HOUR | |
| HARVEY | | Phillip | | NOSSICK | | | | 11 Month 7 Day 68 Year | | 3:30A M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | | 6 AGE (n years lost birthday) | | 7 UNDER 24 HRS | |
| MALE | | WHITE | | 5/27/1909 | | | | 59 YRS | | MONTHS DAYS HOURS M M | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE COUNTY Md | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| FORT HOWARD | | VET. ADM. HOSPITAL | | | | MECHANIC | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| MARYLAND | | DORCHESTER | | HURLOCK | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD 2 | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15 MOTHER'S M A D E N NAME First Middle Last | | | | | | | |
| JOHN HOSSICK | | | | ANNA WHITELY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | | | | |
| YES | | WW 11 | | 216 10 28 53 | | CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | |
| 4274 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC DECOMPENSATION | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ATRIAL FIBRILLATION | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 4331 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/5/68, 19, to 11/7/68, 19, that (I) (we) last saw the deceased alive on 11/7/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c DATE SIGNED | |
| ERHARD J. BUNYOR | | | | | | | | | | 11/7/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | | | |
| ERHARD J. BUNYOR, M. D. | | | | | | VAH FORT HOWARD, MARYLAND | | | | | |
| 23a BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| BURIAL | | 11/11/68 | | OUR LADY OF GOOD COUNCIL CEMETERY, SECRETARY, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| | | | | | | WILLOUGHBY FUNERAL HOME EAST NEW MARKET, MD. | | NOV 14 1968 | | Charles Judge | |



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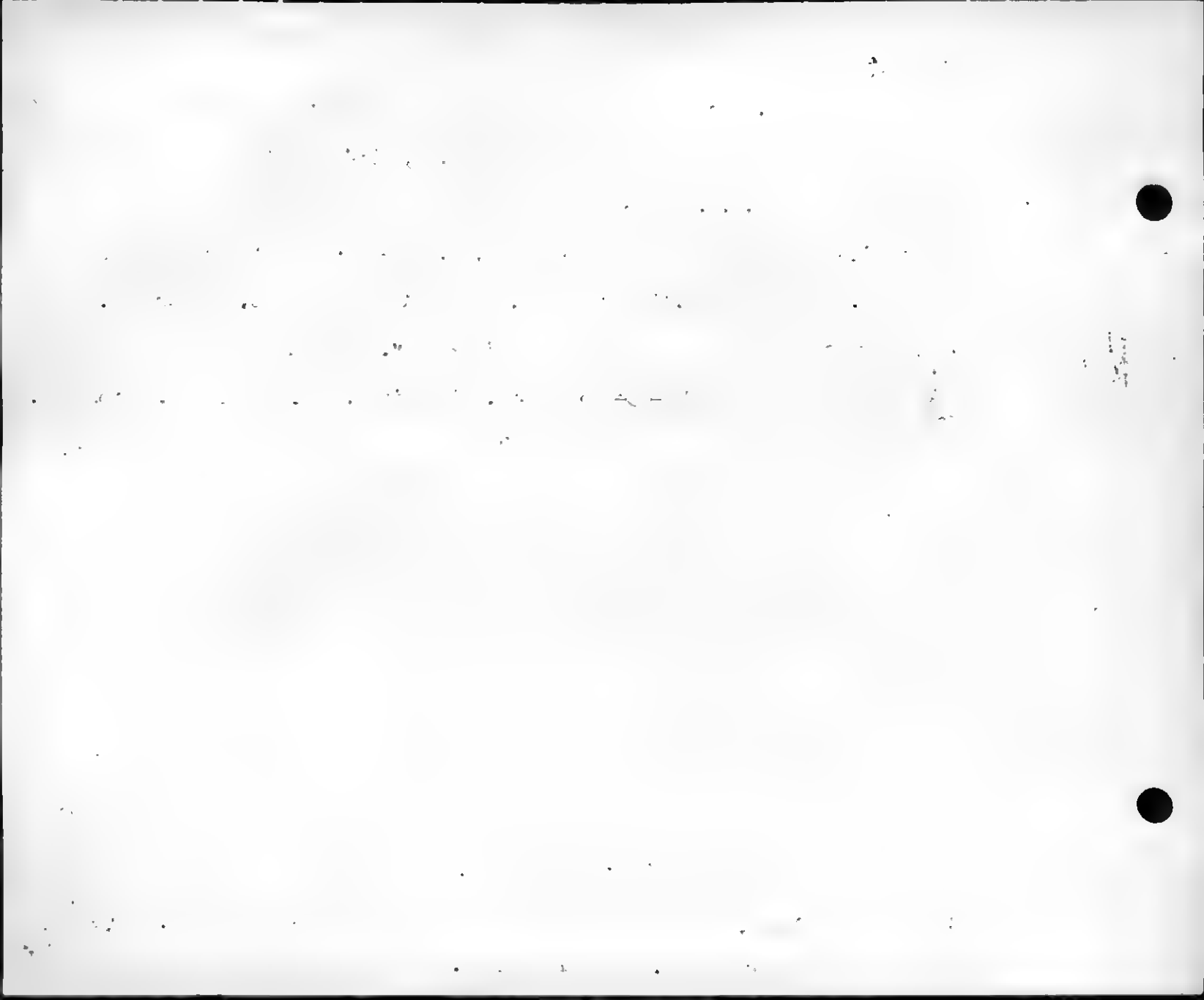
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|-------------------|--|--|---|--|-----------------------------------|-----------------|--|------------------|--|
| 15632 | | 1564 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Alma | | | O'CONNOR | | | Month 11 Day 8 Year 1968 | | | 9:55 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | December 9, 1893 | | | 74 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore, Md | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Towson | | St. Joseph Hospital | | | Homemaker | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Maryland | | Balto. | | Baltimore | | | | 6823 Blenheim Rd. | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Jacob F. Obrecht | | | | Amelia Yeager | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | |
| Yes, no, or unknown) no | | ----- | | Dr. John A. O'Connor | | | | 6823 Blenheim Rd. 12 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chromotone</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of pancreas</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 157 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from 10/15/1968, to 11/8/1968, that (A) (we) last saw the deceased alive on 11/8/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22e. DATE SIGNED 11/8/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22f. ADDRESS | | | | | | | | | | |
| K. P. Coffey Jr. | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Entombment | | 11/11/68 | | Lorraine | | Balto Co. | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Mitchell-Wiedefeld Home-6500 York Rd 21212 | | | | DATE NOV 18 1968 | | J. Charles Judge | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

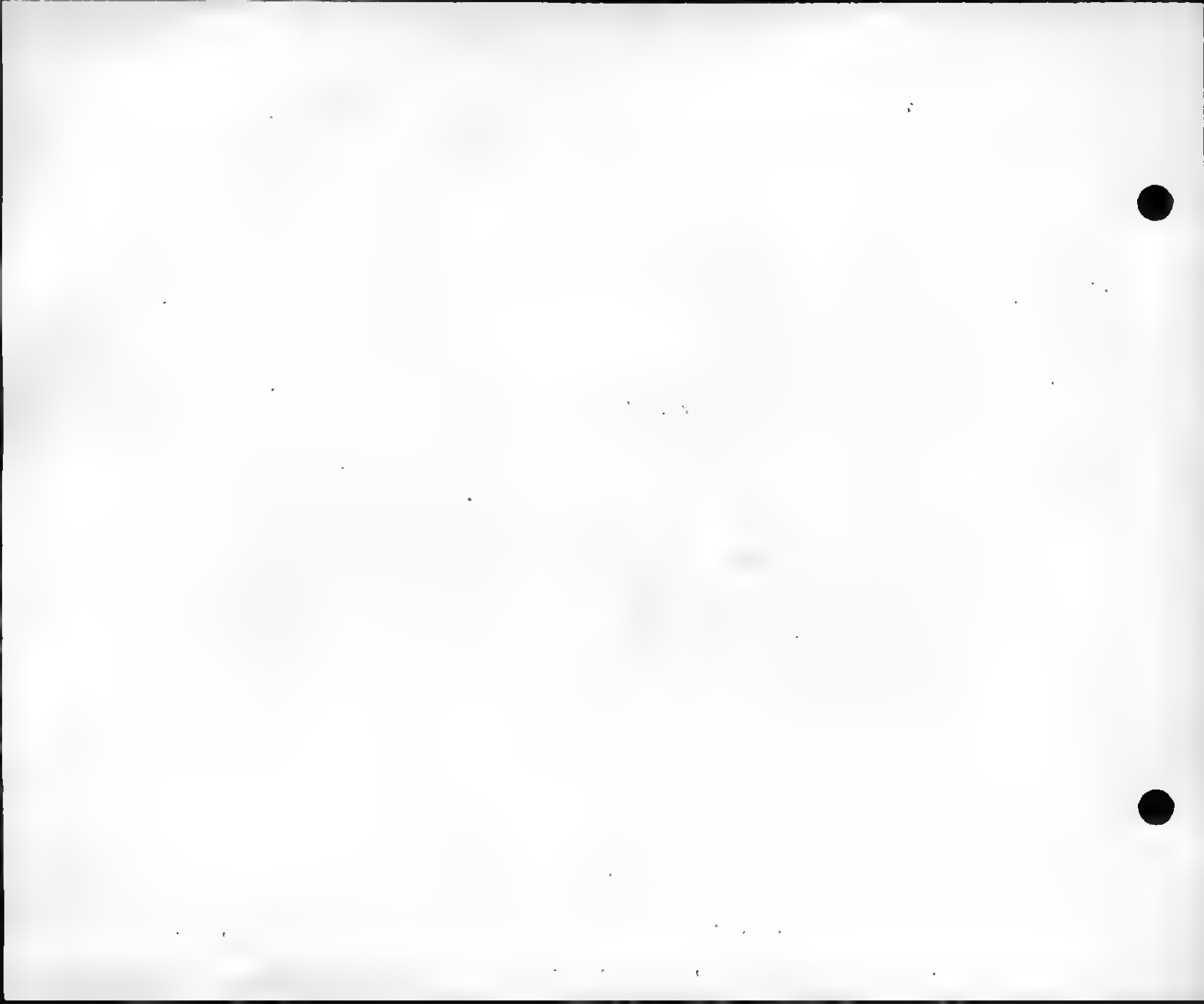
| <div style="display: flex; justify-content: space-between;"> 15634 MARYLAND STATE DEPARTMENT OF HEALTH 15648 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|---|------------------|--|
| 1. DECEASED-NAME (Type or print) Charles E. Oler | | | | | | 2a. DATE OF DEATH 11 Month 14 Day 68 Year | | | 2b. HOUR 5:00 M | | |
| 3. SEX M | | 4. RACE White | | 5. DATE OF BIRTH Oct. 2, 1885 | | 6. AGE (In years last birthday) 83 YRS. | | 7. UNDER YEAR MONTHS DAYS HOURS MIN | | 8. UNDER 24 HRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor N. H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Maintainer | | | 12b. KIND OF BUSINESS OR INDUSTRY Florist Bns | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Ba.to. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6514 Mt. Vernon Ave. | | |
| 14. FATHER'S NAME First Middle Last Joshua Oler | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Florence V. Sprinkle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO 215-03-4669 | | 17. INFORMANT Address Mrs. Virginia M. Dillon 6514 Mt. Vernon Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 1004 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7824 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 Jan 1968 to 14 Nov 1968 , that (I) (we) last saw the deceased alive on 14 Nov 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William Goodman, MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 15 Nov 68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, MD | | | | | | 22e. ADDRESS 1358 South St. Bk | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION (City or Town) (County) (State) Windsor Mill Rd. Maryland | | | | | |
| 24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown Md. | | | | | | 25a. REC'D BY REGISTRAR NOV 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

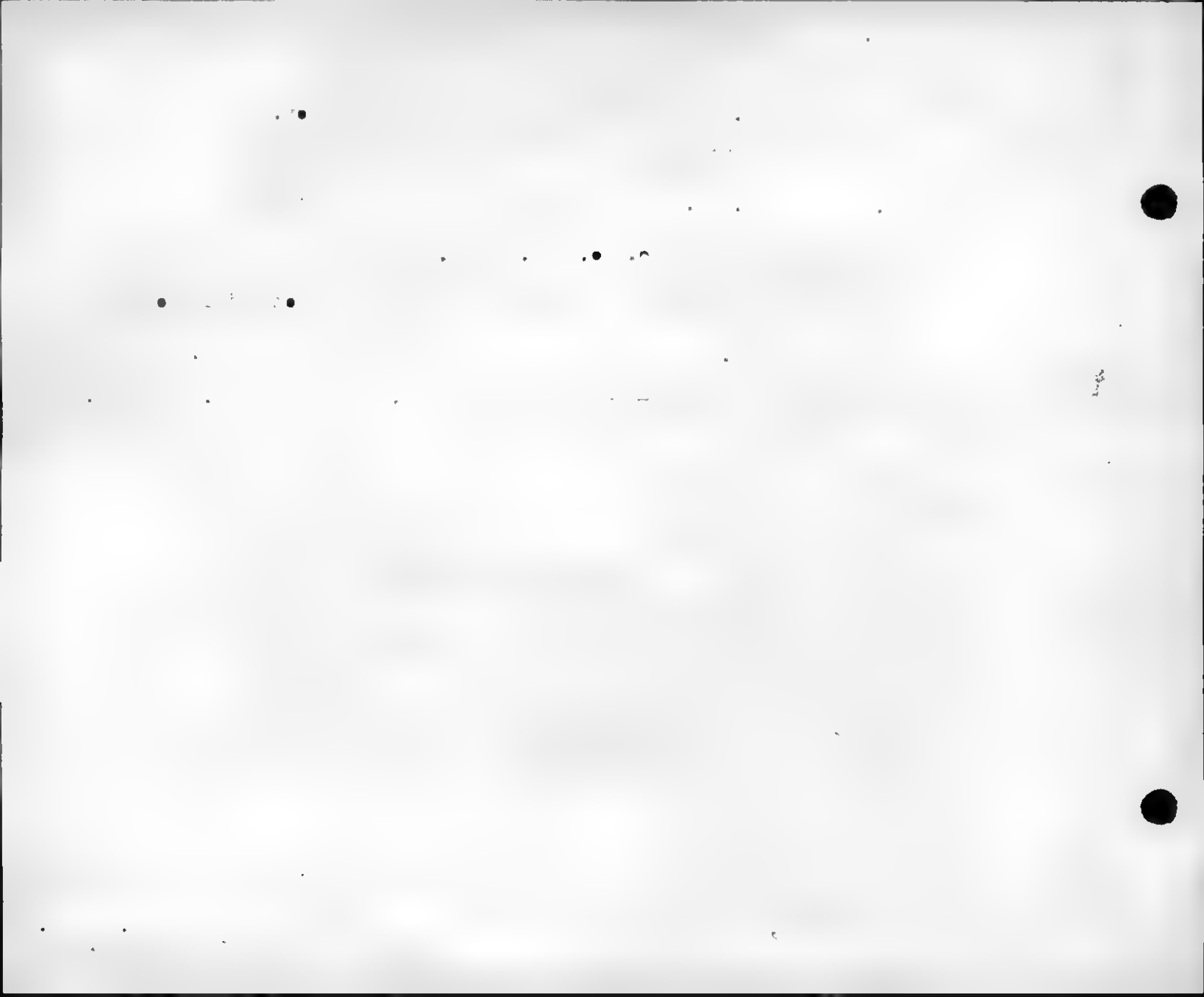
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| Item 8 Film 407 12/5/68 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15649 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15635 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) JOHN F. OSBORNE | | | | | | | | | | 2a DATE OF DEATH Month NOVEMBER Day 30, 1968 | | | | | | | | | | 2b HOUR 1:15 a.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX MALE | | | | | | | | | | 4 RACE WHITE | | | | | | | | | | 5 DATE OF BIRTH 10-6-1927 | | | | | | | | | | 6 AGE (In years last birthday) 41 YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) NORTH CAROLINA | | | | | | | | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9 COUNTY OF DEATH BALTIMORE Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH TOWSON #4 | | | | | | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL | | | | | | | | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | | | | | | | 13b COUNTY BALTIMORE | | | | | | | | | | 13c CITY OR TOWN SPARKS | | | | | | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e STREET AND NUMBER RT. 1, BOX 372 | | | | | | | | | | | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last | | | | | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | | | | | | 16b SOCIAL SECURITY NO. 245 42 9384 | | | | | | | | | | 17 INFORMANT Nora Green Hospital Records Address | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GANGRENE OF SMALL BOWEL DUE TO, OR AS A CONSEQUENCE OF volvulus and extensive bands and adhesions. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION 11-28-1968 | | | | | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED Possible bleeding ulcer | | | | | | | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | | | | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a I certify that (X) (this hospital) attended the deceased from NOV. 26, 1968, to NOV. 30, 1968, that (X) (we) last saw the deceased alive on NOV. 30, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Christina Feliciano, M.D. | | | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | | | 22c DATE SIGNED NOV. 30, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) Christina Feliciano, M.D. | | | | | | | | | | 22e ADDRESS 7620 York Road, Towson 4, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b DATE Dec. 3, 1968 | | | | | | | | | | 23c NAME OF CEMETERY OR CREMATORY Bosley Methodist | | | | | | | | | | 23d LOCATION (City or Town) (County) (State) Baltimore, Co. Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | | | | | | | | ADDRESS | | | | | | | | | | 25a REC'D BY REGISTRAR DATE DEC 2 1968 | | | | | | | | | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



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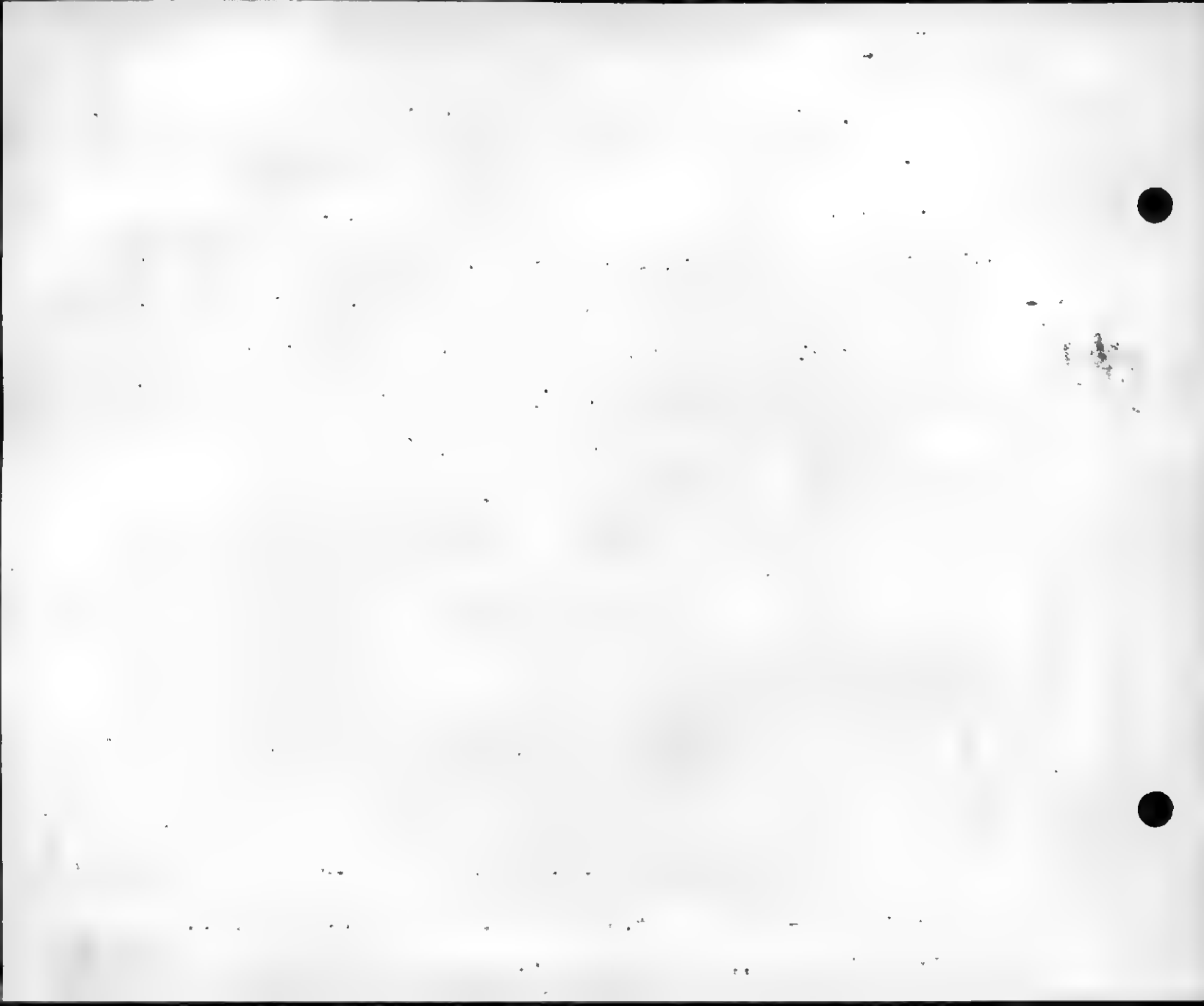
| | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|-----------------------------------|---|--|--|
| Item 15, Telephone Call- Funeral Home 12/DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 5, 6 Film G 407 12/6/68 11w CERTIFICATE OF DEATH Film 407 12-9-68ams | | | | | | | | | | | | |
| 1. DECEASED NAME (Type of name) First Middle Last George N. Page | | | | | | 2a. DATE OF DEATH Month Day Year Nov. 26 68 | | | 2b. HOUR M | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH April 17, 1893 | | 6 AGE (In years last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Balto. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hospt. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) State | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Owings Mills | | 13d. INSIDE CITY, Y.N. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Lyons Mills Road | | |
| 14 FATHER'S NAME First Middle Last George S. Page | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Laura V. Welsh Page | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) | | | | 16b. SOCIAL SECURITY NO 220-03-9185 A | | 17 INFORMANT Address James N. Page 3506 St. James Rd. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ASCD. DUE TO, OR AS A CONSEQUENCE OF (b) 2 yrs DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or RFD No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1961 to 11/27 , 19 68 , that (I) (we) last saw the deceased alive on 11/25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE W. J. E. Llin | | | | DEGREE M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11/27/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) M. J. E. Llin | | | | 22e. ADDRESS Randallstown, Md 21133 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 30, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | | | 23d. LOCATION (City or Town) (County) (State) Pikesville Balto. Md. | | | | |
| 24 FUNERAL DIRECTOR Loring Byers | | | | ADDRESS 8728 Liberty Road 21133 | | | | 25a. REC'D BY REG. STRAP DEC 2 1968 | | 25b. REG. STRAP SIGNATURE J. J. Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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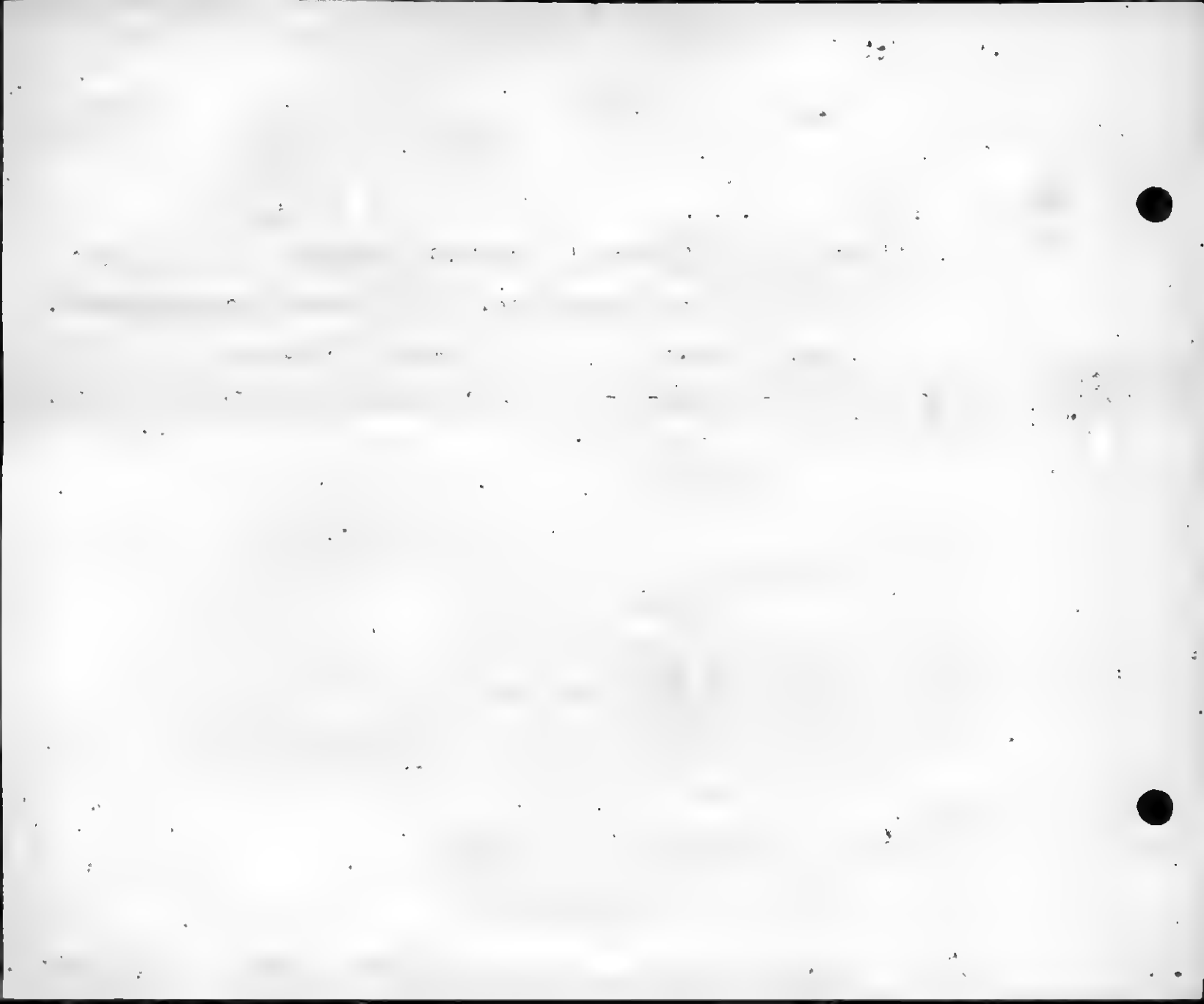
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|---|---|--|-----------------------------------|--|
| 15637 | | 15651 | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| DORA | | | V | PALMER | | Month | Day | Year | 1:10 A.M. |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. YRS. | |
| FEMALE | WHITE | | JULY 29 1889 | | | 79 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| VIRGINIA | | U.S.A. | | | | BALTO. CO. Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTO. CO. | | | 5702 KENWOOD AVE | | | HOUSEWIFE | | HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD. | | | BALTO. BALTO. CO. | | | YES | | 5702 KENWOOD AVE. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| DARFIELD ANTHONY | | | EMMA HENDERSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | Address | |
| NO | | | 217-54-2296 | | | MRS. C. D. NATALE | | 5702 KENWOOD AVE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral hemorrhage | | | | | | | | | May 1968 |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | Placental |
| (b) arterial blood supply failure | | | | | | | | | mar 1968 |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Thrombosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 331 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 1968, that (I) (we) last saw the deceased alive on Nov-7-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| Ralph G. Hillis MD | | | | | Nov-14-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| RALPH G. HILLIS | | | | | 18 EAGER ST. BALTO 21202 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11-16-68 | | Mt. Carmel Cem. | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Lilly & Zeiler, Inc., 1901 Eastern Ave., Baltimore, Md. 21231 | | | | | NOV 15 1968 | | [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15638 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 1566 | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|-----------------|--|-------|--|----------------------------|--|--|--|----------|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | First Middle Last | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| Mary Panza | | | | | | | | | | | | | | | | | | | | Nov 11 1968 | | | | M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | | | 7. UNDER YEAR | | 8. UNDER 24 HRS | | | | | | | | | |
| Female | | | White | | | March 13, 1902 | | | | 66 | | | | MONTHS | | DAYS | | HOURS | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Maryland | | | U.S.A. | | | | | | | Baltimore | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | | St Joseph's Hospital | | | Housewife | | | | | | | | None | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | | | | | | | | | |
| Md | | | Baltimore | | | Balte. | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 6626 Loch Raven Blvd. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | |
| Giacome Trotta | | | Carmela Ferlenza | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | Address | | | | | | | | | | | | | | | |
| No | | | 215-18-6827 | | | Americo Panza | | | | 6626 Loch Raven Blvd. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | Acute myocardial infarction. | | | | | | | | | | 3 hours | | | | | |
| 4104 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Coronary Ischemia, right bundle branch block. | | | | | | | | | | 5 years | | | | | |
| | | | | | | | | | | (c) Arteriosclerotic coronary vascular disease. | | | | | | | | | | 5 years. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | Possible carcinoma of uterus, pelvis. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | Street or R.F.D. No. | | | | City or Town | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | Street or R.F.D. No. | | | | City or Town | | | | County | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 11-11-1968, that (I) (we) last saw the deceased alive on 10-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | |
| Martin J. Feldman, M.D. | | | | | | | | | | 11/14/68 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Martin J. Feldman, M.D. | | | | | | | | | | 1 Cherry Hill Rd. Reistertown, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) | | | | (County) (State) | | | | | | | | | | | |
| Burial | | | 11/15/68 | | | Dulaney Valley Memorial Gardens | | | | Towson | | | | Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Joseph N. Zannone | | | | | | | | | | NOV 19 1968 | | | | | | | | | | Charles Judge | | | | | |



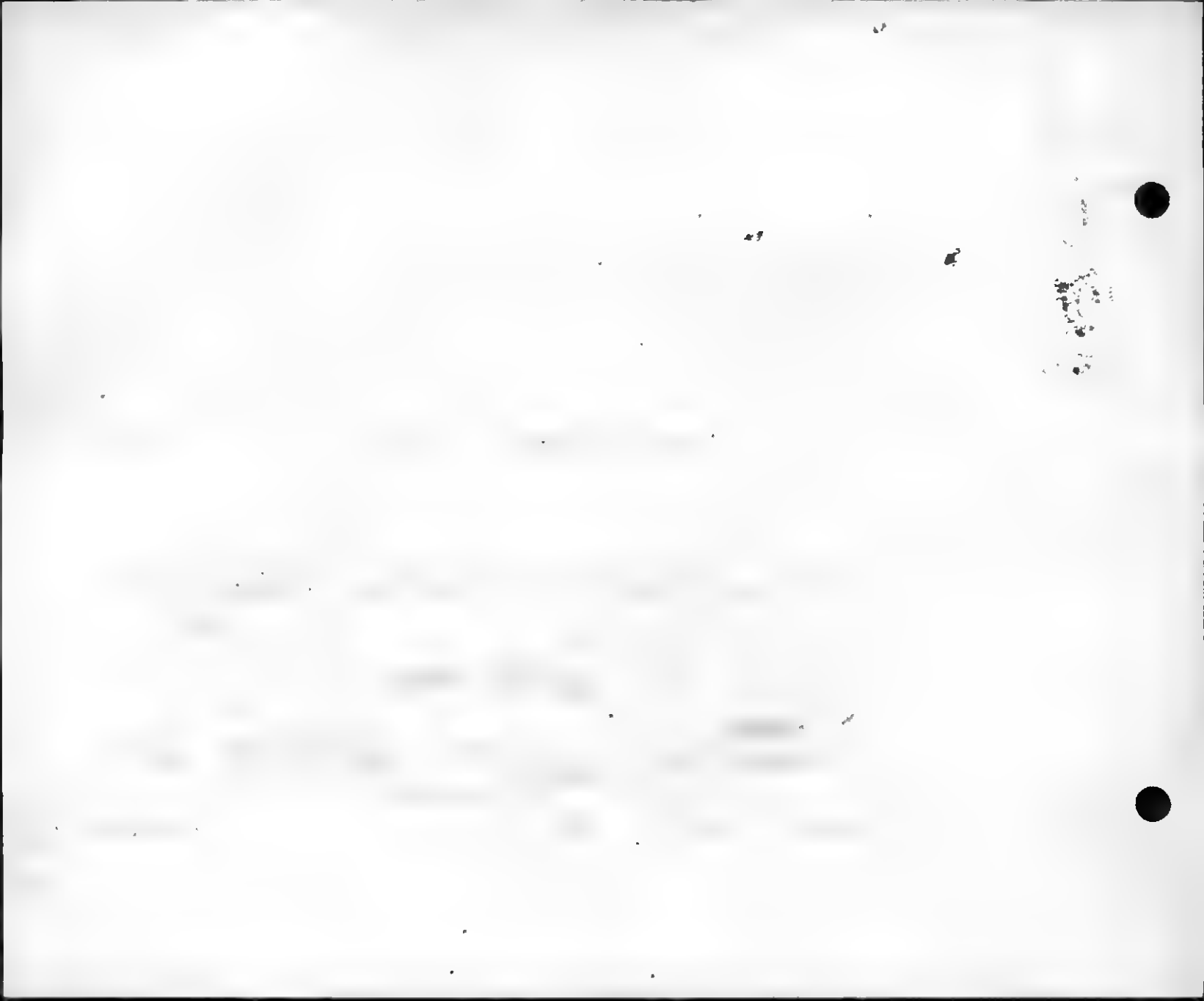
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15639

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15653
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|-------------------------------|---|---|--|--|--|--|
| 1 DECEASED-NAME (Type or print) First Middle Last Aura Cassandra Parks | | | 2a. DATE OF DEATH 11 Month 22 Day 68 Year | | | 2b. HOUR M | | | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH 9-18-84 | | 6 AGE (In years last birthday) 84 YRS | | 7 UNDER 1 YEAR MONTHS DAYS | | 8 UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County Md. | | | | | |
| 10 CITY OR TOWN OF DEATH Randallstown | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Balto. Co. Gen. Hosp | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USLA: RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b COUNTY Balto | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 3524 Essex Rd | | |
| 14 FATHER'S NAME First Middle Last Phillip Price | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Cassandra Rickman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If give war or dates of service) NO NO | | | | 16b. SOCIAL SECURITY NO. 217-18-66953 | | 17 INFORMANT Address Mrs. Eula P. Leialoha 3524 Essex Rd. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphocytic leukemia</u> 2041 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2640</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months-Years Months-Years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary edema, congestion + Atelectasis - Fracture Rt hip</u> | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year PM 11 19 1968 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell down</u> | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>HOME</u> | | 21f LOCATION Street or RFD No | | City or Town | | County | | State | |
| 22a I certify that (I) (th's hospital) attended the deceased from <u>11-19</u> , 19 <u>68</u> to <u>11-22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE <u>Samuel Call, MD</u> | | | | 22c DATE SIGNED 11-23-68 | | | | 22d PHYSICIAN'S NAME (Type) ADDRESS | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | November 25, 68 | | Rock Creek Cem. | | Chance Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a RECD BY REGISTRAR DATE | | 25b REGISTRAR'S SIGNATURE | | | | | |
| Loring Evers 8728 Liberty Rd. Randallstown, Md. | | | | NOV 25 1968 | | <u>Charles Judge</u> | | | | | |

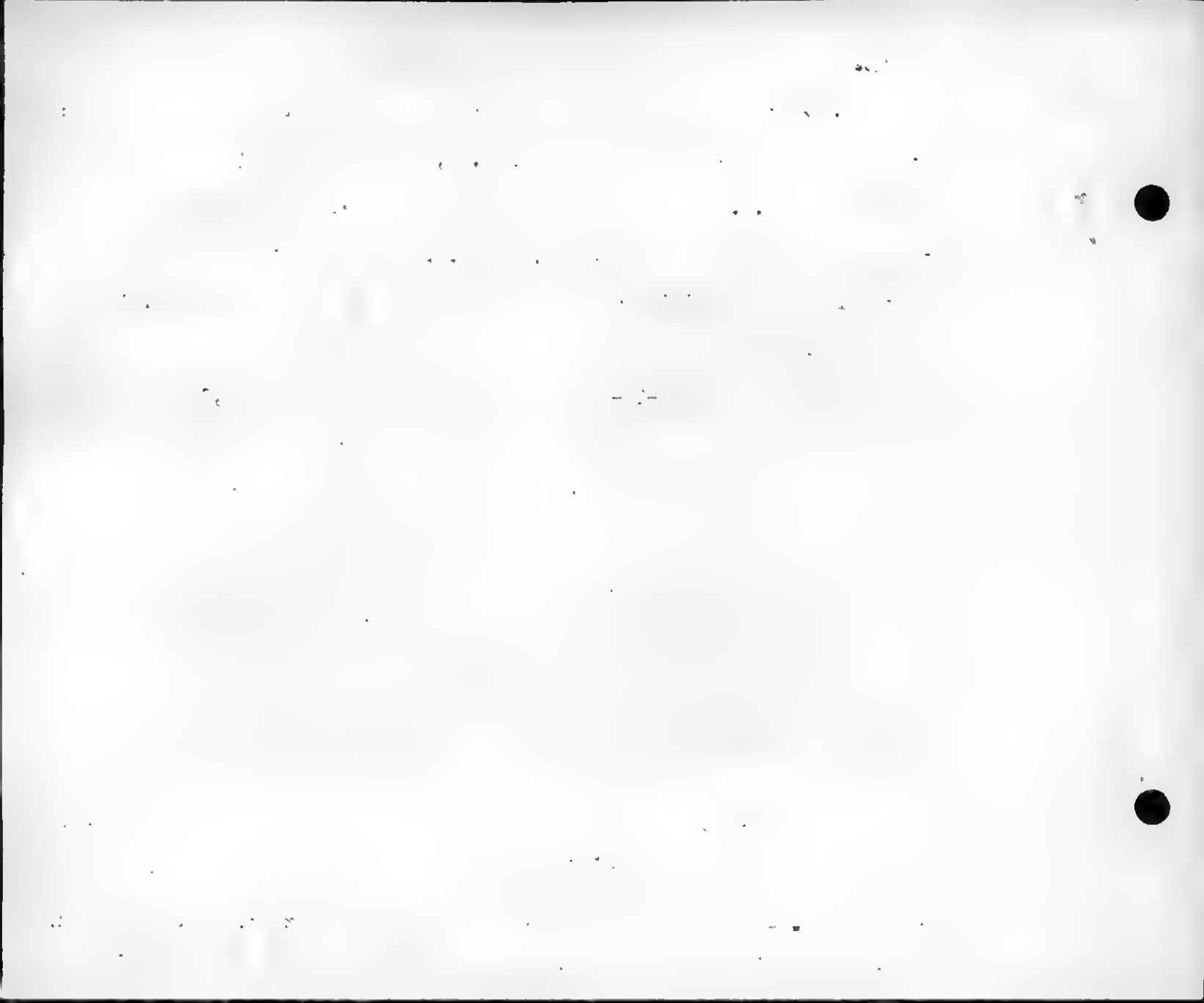


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113-41
30M REV 11/68

| <div>15640</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #6, File #2426 11/22/68 km</div> <div>CERTIFICATE OF DEATH</div> <div>1565</div> | | | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|---|--|------------------------------|
| 1. DECEASED NAME (Type or print) Elizabeth Parks | | | | | | 2a. DATE OF DEATH 11 Month 4 Day 68 Year | | | 2b. HOUR 4:30pm | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Dec. 31, 1884 | | | 6. AGE (In years lost birthday) 83 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Tennessee | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County Md | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Ridge N.H. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 3305 Kessler Ct. 21227 | | |
| 14. FATHER'S NAME First Middle Last Anthony Selwah | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Nancy Powell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 214-24-9575 | | 17. INFORMANT Address Caton Ridge Nursing Home, 329 Harlem Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA & L. hemiparesis 467 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331X (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of breast & Metastases | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-3-1962 , to 11-4-1962 , that (I) (we) last saw the deceased alive on 11-4-1962 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Cesar Valle Caverio | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-5-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO | | 22e. ADDRESS 86 24 Liberty Rd | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-8-68 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Belair Rd. Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Ralph Patrick Pass</i> | | | 2a. DATE OF DEATH Month Day Year <i>November 14 1968</i> | | 2b. HOUR <i>5:30 PM</i> |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>April 4, 1897</i> | | 6. AGE (In years last birthday) <i>71</i> | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Hampstead</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Lower Road Beckleysville</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i> | 13b. COUNTY <i>Baltimore</i> | 13c. CITY OR TOWN <i>HAMPSTEAD</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <i>Lower Beckleysville Rd</i> | |
| 14. FATHER'S NAME First Middle Last <i>John Pass</i> | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Batherine Gallagher</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) <i>No</i> | | |
| 16b. SOCIAL SECURITY NO. <i>214-18-5532</i> | | 17. INFORMANT Address <i>Baltimore Pass Hampstead Md</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1621 Broncho-pneumonia Right Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>-</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 23, 1968</i> , to <i>Nov 14, 1968</i> , that (I) (we) last saw the deceased alive on <i>Nov 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Joseph E. Bual MD</i> | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <i>11-14-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bual MD</i> | 22e. ADDRESS <i>Hampstead Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>Nov. 17, 1968</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Forest Cemetery</i> | 23d. LOCATION (City or Town) (County) (State) <i>Upperco, Md.</i> | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>Tipton - Eline Funeral Home Hampstead, Md.</i> | | 25a. REC'D BY REGISTRAR <i>Nov 18 1968</i> | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30M (REV) 1/68

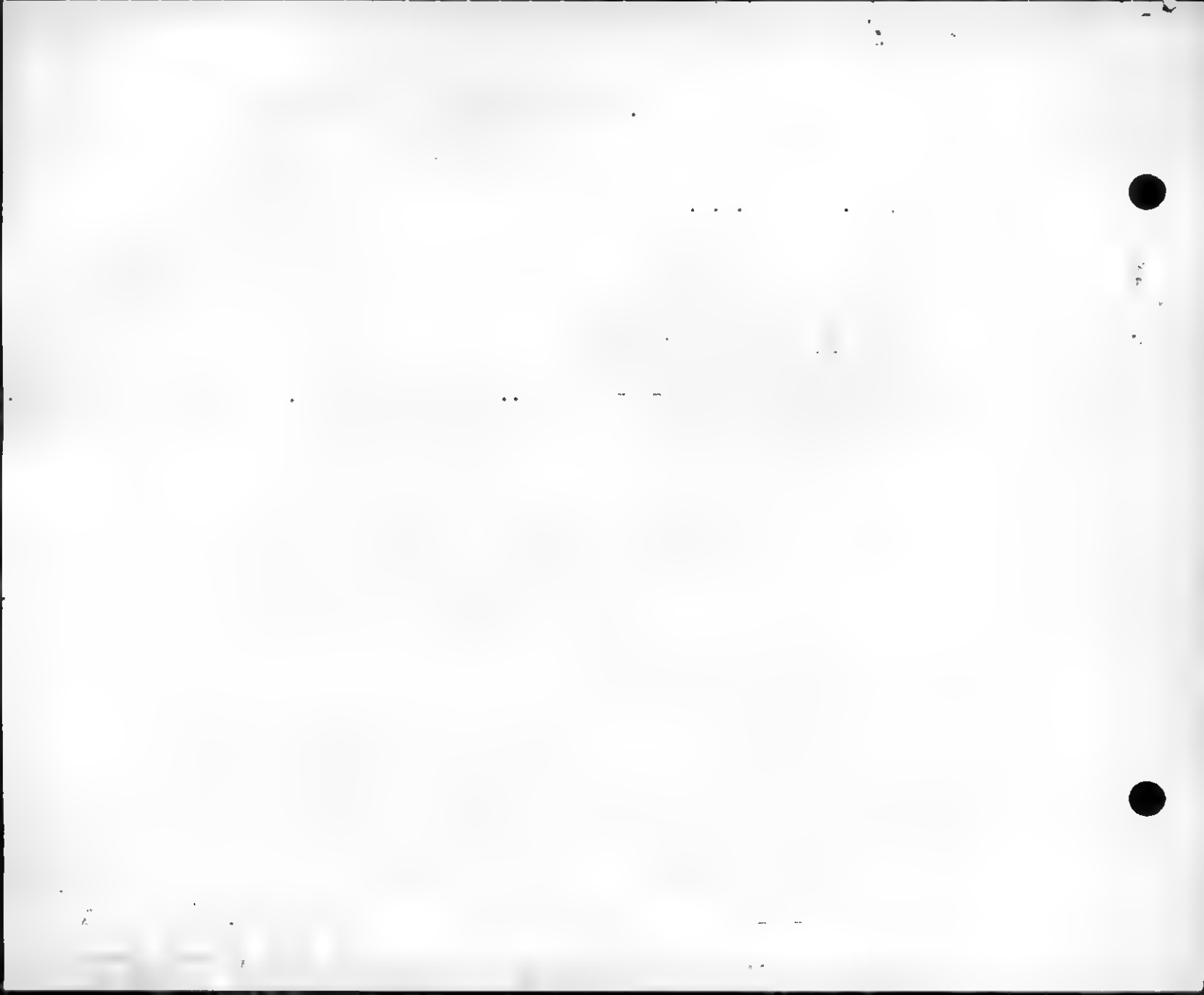
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15648

CERTIFICATE OF DEATH

15656

| | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) ALVIN | | | First Middle Last A. PATTASHNICK (PATT) | | | 2a. DATE OF DEATH Month NOVEMBER Day 24 Year 1968 | | | 2b. HOUR 9 P.M. | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 11-26-1910 | | | 6. AGE (In years last birthday) 57 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) RICHMOND, VA. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3911 SOUTHERN CROSS DRIVE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) JEWELER | | | 12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Res dence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER 3911 SOUTHERN CROSS DRIVE | | | 14. FATHER'S NAME First Middle Last SAMUEL PATTASHNICK | | | 15. MOTHER'S MAIDEN NAME First Middle Last BESSIE WEBER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 223-03-7455 | | | 17. INFORMANT MRS. JEAN PATTASHNICK | | | Address 3911 SOUTHERN CROSS DR. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant brain tumor 171X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) e 2a Tumor DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1430 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 60 to Nov 14 1968 , that (I) (we) as- sow the deceased alive on Nov 14 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Nathan Needle | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS | | | 22c. DATE SIGNED Nov 25/68 | | |
| 22d. PHYSICIAN'S NAME (Type) NATHAN NEEDLE | | | 22e. ADDRESS 6506 PARK HEIGHTS AVENUE | | | | | | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL | | | 23b. DATE 11-27-68 | | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL | | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., | | | ADDRESS 6010 REISTERSTOWN ROAD | | | 25a. REC'D BY REGISTRAR NOV 27 1968 | | | 25b. REG-STRAR'S SIGNATURE gcharles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT 15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------------------|---|--|------------------------------------|--|---|------------------------------|--|----------------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | | |
| Sister Ignatia Peach | | | | | | Nov. 30, 1968 | | | M | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (in years last birthday) | | 7c UNDER 1 YEAR | | 7d UNDER 24 HRS | |
| Female | | White | | Apr. 19, 1902 | | | 66 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Maryland | | U. S. A. | | | | Baltimore | | | Academy. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | | | St. Joseph's Nursing Home | | | Teacher, at Mount de Sales | | | Academy. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d STREET AND NUMBER | | | 13e. STREET AND NUMBER | | |
| Maryland | | | Baltimore | | Catonsville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Mount de Sales 700 Academy | | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| James A. Peach | | | Josephine Oliver | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | 17a. ADDRESS | | | 17b. ADDRESS | |
| No | | | 212-58-9165 T | | Sister Francis De Sales | | | 700 Academy Road | | | Catonsville, Md. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) <u>Cerebral Arteriosclerosis</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) <u>Unknown</u> | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | 19 P.M. | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | 21g. LOCATION | | | |
| | | | | | | Street or R.F.D. No. | | | City or Town | | | |
| | | | | | | County | | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>11/30</u> , 19 <u>68</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>11/29</u> , 19 <u>68</u> , and that in my (<u>own</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>was</u>) (<u>did</u>) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | |
| <u>James Nolan MD</u> | | | <u>11/30/68</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| J S NOLAN | | | Baltimore Md 21229 | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) | | | 23e. LOCATION (County) (State) | |
| Burial | | | Dec. 2, 1968 | | Mount de Sales Cemetery | | | Catonsville, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Easton Funeral Home | | | Catonsville, Md. | | | DEC 3 1968 | | | <u>Charles Judge</u> | | | |



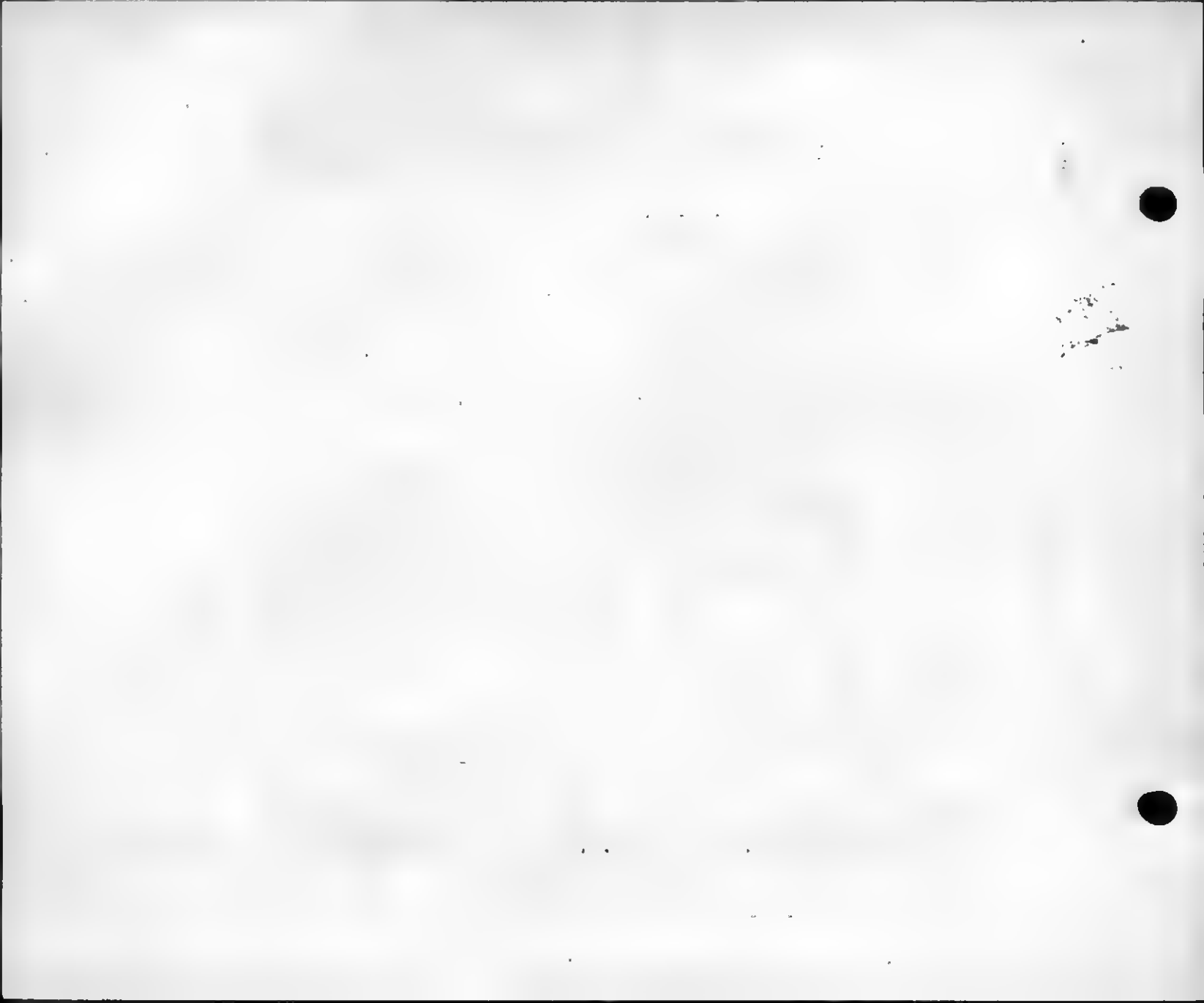
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&22a Film 409 Maryland STATE DEPARTMENT OF HEALTH
-11-69 ans. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
15044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|-----------------|--|---|---|-------------------------------|
| 1 DECEASED-NAME (Type or Print) First Middle Last ROBERT EDGAR PENNINGTON | | | 2a DATE KNOWN OF DEATH Month Day Year Nov. 25, 1968 | | 2b HOUR 6:00 AM |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH 8-21-1937 | 6 AGE (In years last birthday) 31 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Baltimore | | | 2c DATE PRONOUNCED DEAD Month Day Year Nov. 25, 1968 | | 2d HOUR 8:00 AM |
| 10 CITY OR TOWN OF DEATH Arbutus | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1210 Elm Road | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 12b KIND OF BUSINESS OR INDUSTRY Calvert Dist. | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b COUNTY Baltimore | 13c CITY OR TOWN Arbutus | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME First Middle Last Earl Pennington | | 15 MOTHER'S MAIDEN NAME First Middle Last Harriet A. Scarboro | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 216-32-3059 | | 17. INFORMANT ADDRESS Joan C. Wimpling, 1210 Elm Road, Arbutus Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intravenous Narcotism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary tuberculosis</u> | | | | | |
| 19a. DATE OF OPERATION 2-7- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION (Street or R.F.D. No. City or Town County State) | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b DATE SIGNED November 25, 1968 | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b DATE 11-27-68 | | 23c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | |
| 24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave., Baltimore | | 23d LOCATION (City or Town) (County) (State) Baltimore, City, Baltimore Md. | | 25a REC'D BY REG. STRAR NOV 26 1968 | |
| | | | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

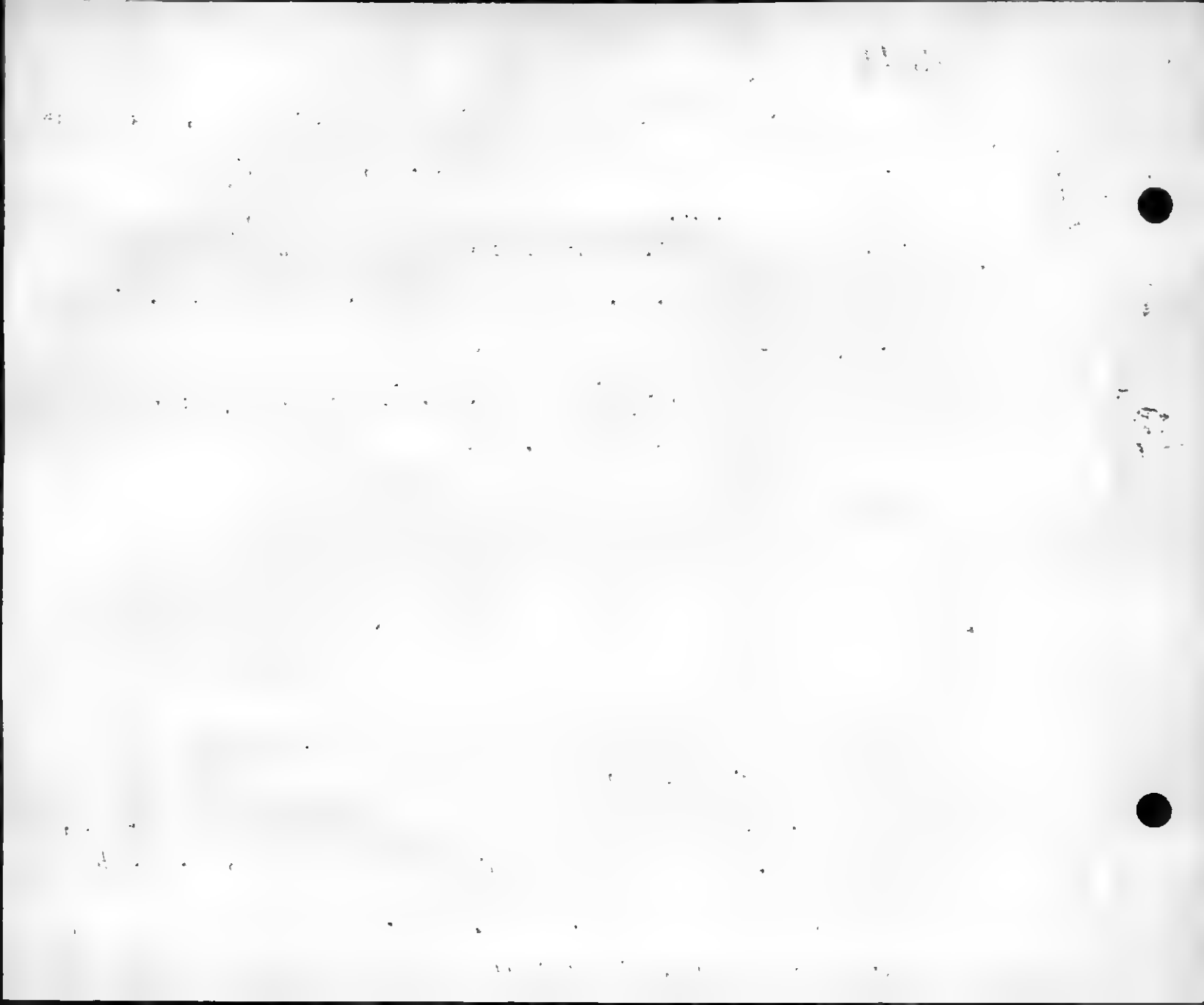
VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15649

15659

| | | | | | | | |
|--|--|--|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) MARIE ANNA PERRY | | | 2a. DATE OF DEATH Month NOVEMBER Day 11 Year 1968 | | | 2b. HOUR 3:45 AM | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH SEPTEMBER 19, 1896 | | 6. AGE (In years last birthday) 72 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of last year, or if retired) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND | | 13b. COUNTY BALTO. CO. | | 13c. CITY OR TOWN TOWSON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last Joseph Kohlhepp | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO. 216-07-8436 | | 17. INFORMANT Address Sydney J. Perry - 8219 Belair Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 5, 19 68 , to November 11 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 11, 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Camilo Z. Tomboc | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED November 11, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) CAMILO Z. TOMBOC | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON, MD. #21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland-21236 | |
| 24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-22206 | | | | 25a. REC'D BY REGISTRAR DATE NOV 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



25

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15660

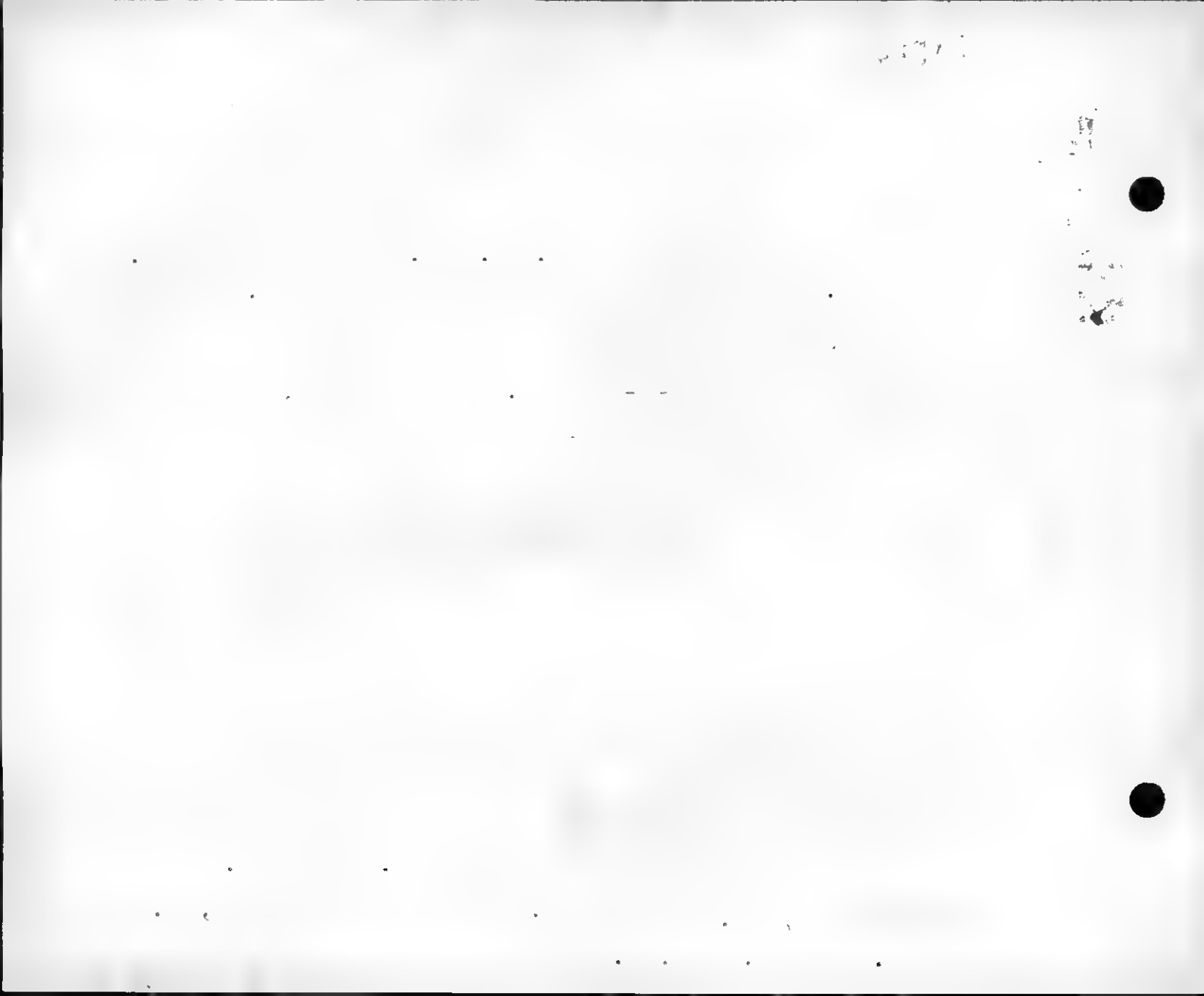
15646

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) CESARE | | First NMN | | Middle PICCININI | | Last | | 2a. DATE OF DEATH Month 11 Day 30 Year 68 | | 2b. HOUR 12:40 | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH 5/13/1896 | | 6. AGE (In years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN _____ | |
| 7a. BIRTHPLACE (State or foreign country) Italy | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. med. Cent. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Clothing Mfr. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 621 St. Francis Road | | | |
| 14. FATHER'S NAME First Augustine Middle Piccinini Last Picene | | 15. MOTHER'S MAIDEN NAME First Frances Middle Picene Last Picene | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (if yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 217-16-8898 | | 17. INFORMANT Address Mr. Anthony Piccinini, 1221 St Andrews Way #12 | | | | | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4d11 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) Heart failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ | | | | | | | |
| 22a. I certify that (I) did not attended the deceased from 11-12 , 19 68 , to 11-30 , 19 68 , that (I) do last saw the deceased alive on 11-30 , 19 68 , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. F. Naeim | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-30-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) FARAMARZ NAEIM | | 22e. ADDRESS 6701 N. Charles St. | | | | | | | | | |
| 23a. BURIAL CREMATION Entombment | | 23b. DATE 12/3/68. | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Mausoleum | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | 25a. REC'D BY REGISTRAR DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15661 | |
|--|--|---|---|---|--|--|--|---|------------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) Theodore J. Piechocki | | | | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Nov 12 68 | | 2b HOUR 8:40 A.M. | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 12-17-07 | | 6 AGE (in years last birthday) 60 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore | | |
| 10 CITY OR TOWN OF DEATH Sparrows Point, Md. | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beth. Steel Disp. Sp Pt. Md. | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician | | 12b KIND OF BUSINESS OR INDUSTRY Ship Building | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | | 13b COUNTY | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e STREET AND NUMBER 2316 Foster Ave. | |
| 14 FATHER'S NAME First William Middle Piechocki Last | | | | | | 15 MOTHER'S MAIDEN NAME First Pelagia Middle Swiecikowski Last | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b SOCIAL SECURITY NO 213-07-4298 | | 17 INFORMANT ADDRESS Mr. Melvin J. Pryor, 3414 Pinewood Ave | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V-D DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) 4201 N | | | | | | | | | | | |
| 19a DATE OF OPERATION 11/15/68 | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? N | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. 9 P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis | | | | | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED Nov 12, 1968 | |
| EXAMINER'S NAME (Type) Melvin B Davis M. D. | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town or county) | |
| 23a BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | | 23b DATE 11/15/68 | | 23c NAME OF CEMETERY OR CREMATORY Holy Rosary | | | 23d LOCATION (City or Town) Baltimore, | | (County) Md. (State) | |
| 24 FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE. | | | | | | 25a REC'D BY REGISTRAR NOV 14 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |



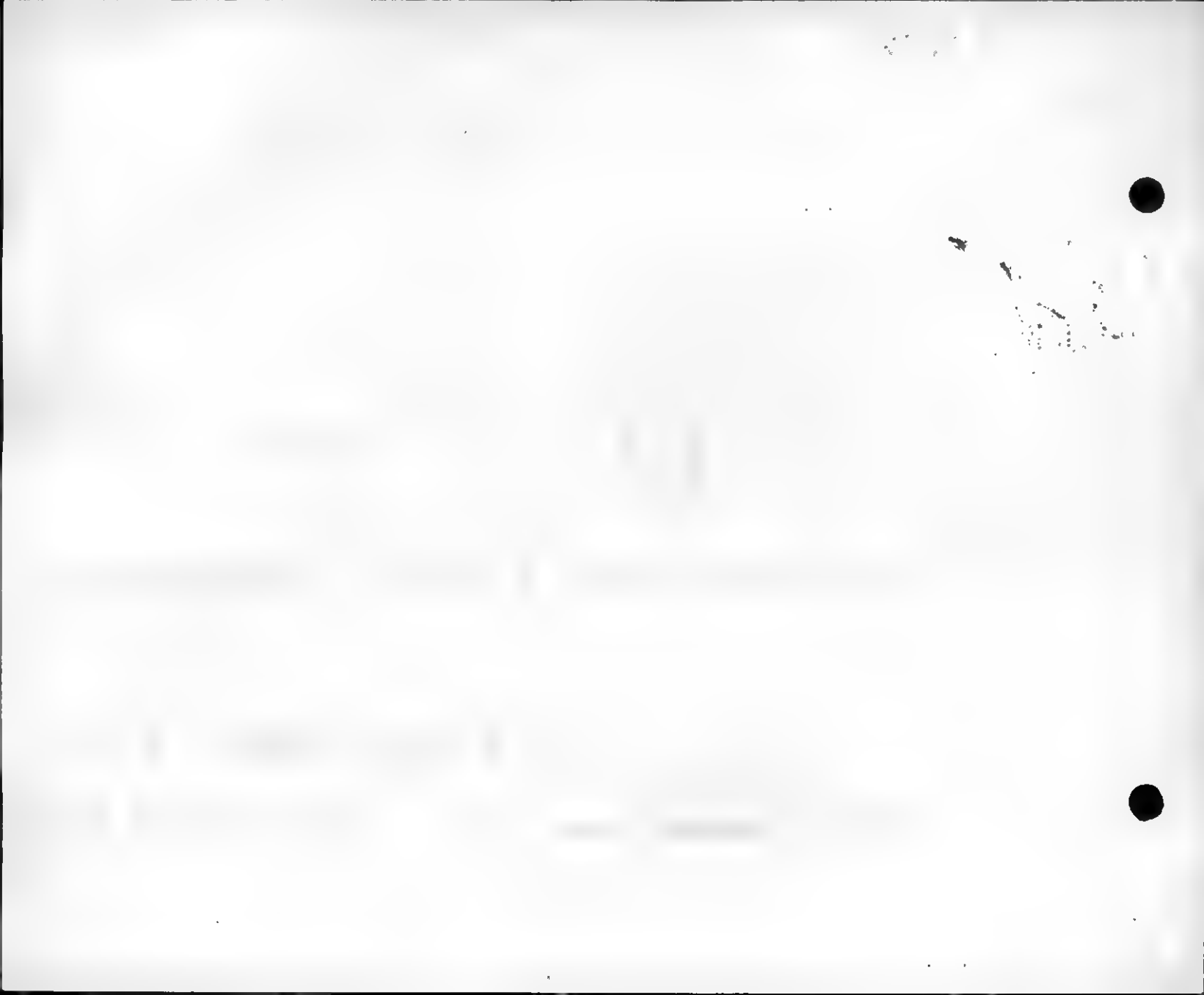
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15643 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) <i>Lillie</i> | | | First Middle Last <i>E Poling</i> | | | 2a. DATE OF DEATH Month <i>Nov</i> Day <i>21</i> Year <i>68</i> | | 2b. HOUR <i>3:4</i> M. | |
| 3 SEX <i>Female</i> | | 4. RACE <i>White, Caucasian</i> | | 5. DATE OF BIRTH <i>1/10/83</i> | | 6. AGE (In years last birthday) <i>85</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>St. Clair W.V.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Randallstown Md</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balt. Co. General</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Owings Mills</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>107 Willgate Rd.</i> | |
| 14. FATHER'S NAME First Middle Last <i>James Davis A</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>M A Mary Hersheeman</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> or unknown | | 16b. SOCIAL SECURITY NO <i>215-54-1185</i> | | 17. INFORMANT <i>Chart</i> | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Insufficiency</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>334X</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Heart Disease; Bronchopneumonia</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 17</i> 19 <i>68</i> , to <i>Nov 21</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Nov 21</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Dr. Hewson</i> DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>Nov 21, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>11/25/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lake View</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Carroll Co. Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i> | | | | 25a. REC'D. BY REGISTRAR <i>NOV 25 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Morris | | | Potlock | | | NOV. Month Day Year | | 6:50 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | 8-6-06 | | 62 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| BALTIMORE, MD. | | USA | | | | Baltimore | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Randallstown | | | Balto Co Gen | | | PROPRIETOR | | TAXI CAB | |
| 30. US. AL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| Md. | | | Balto | | | Randallstown | | 8523 Glen Michael La | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JACOB | | | POTLOCK | | | SARAH FRIEDMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| NO | | | 217-03-8728 | | | MRS. CECILIA POTLOCK, 8523 GLENN MICHAEL LANE APT. 104 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary malignancy</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 162 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> , 19 <u>68</u> , to <u>11-11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-11</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| <u>G. Taylor</u> | | | | | | | | | <u>11-11-68</u> |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | BALTIMORE COUNTY GENERAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 11-13-68 | | MOSES MONTIFIORRE | | BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | DATE | | <u>NOV 14 1968</u> <u>J. Charles Judge</u> | | |

1944-1945
1946-1947




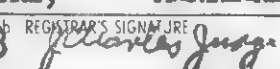
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

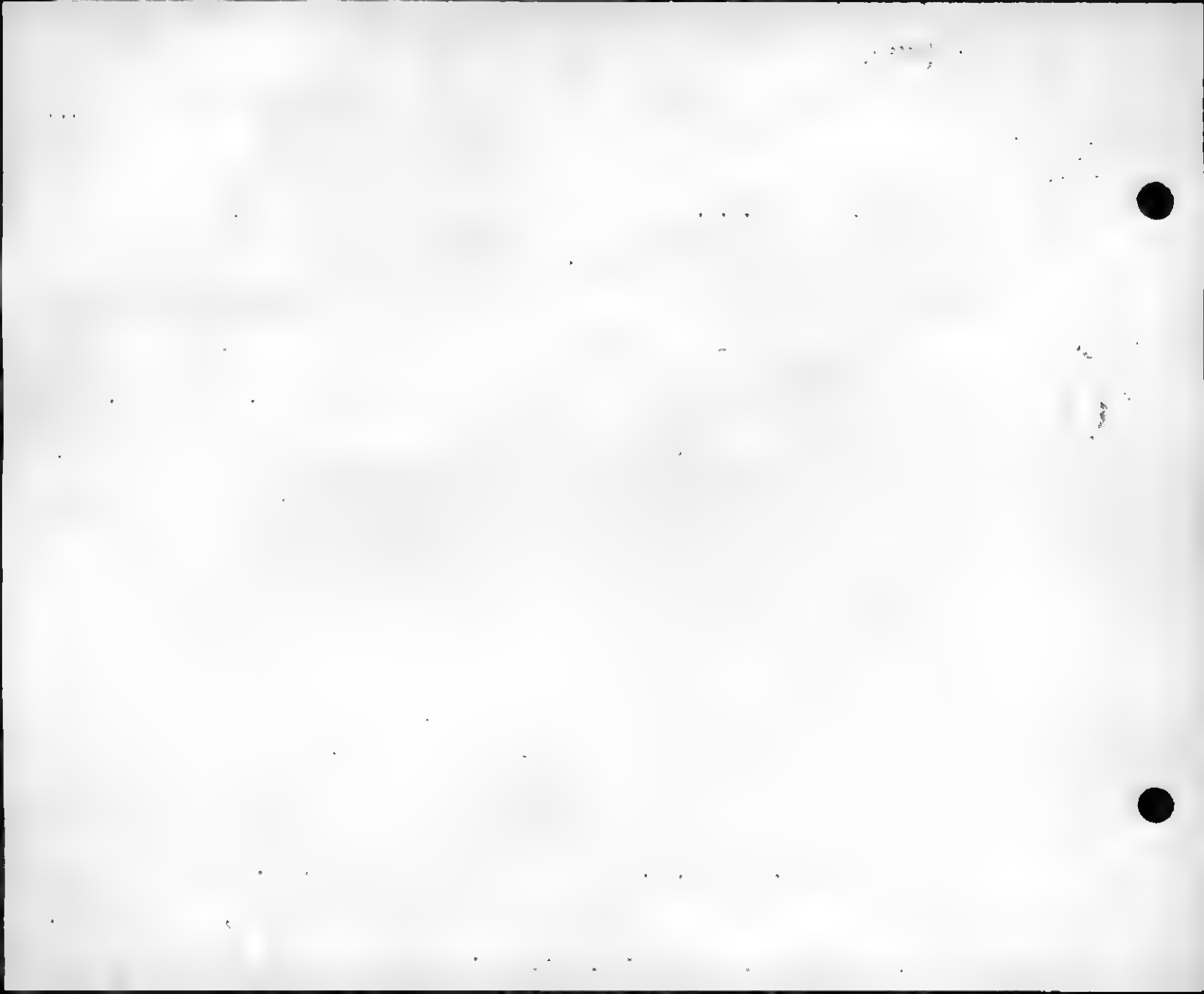
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1
15650
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15664

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED-NAME (Type or print) KENNETH ALLEN PRENTISS | | | 2a. DATE OF DEATH Month NOVEMBER Day 11 , Year 1968 | | 2b. HOUR 4:40AM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 4/13/25 | | 6. AGE (In years last birthday) 43 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH BALTIMORE Md | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BARTENDER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 417 SOUTH CLINTON STREET | |
| 14. FATHER'S NAME First Middle Last HAROLD - - PRENTISS | | 15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE - - HUGHES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES WWII (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 188 16 66 55 | 17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA TO BRAIN, KIDNEY, LYMPH NODES DUE TO, OR AS A CONSEQUENCE OF (c) - - - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS MONTHS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) - - - | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (1) (this hospital) attended the deceased from OCT 10 , 19 68 , to NOV 11 , 19 68 , that (1) (we) last saw the deceased alive on NOV 11 , 19 68 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE  | | | | 22c. DATE SIGNED 11/11/68 | |
| 22d. PHYSICIAN'S NAME (Type) MARIO J. QUIROS, M.D. | | | | 22e. ADDRESS VAH, FT. HOWARD, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL | 23b. DATE 11/14/68 | 23c. NAME OF CEMETERY OR CREMATORY LOUDON NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND. | |
| 24. FUNERAL DIRECTOR JOSEPH N. ZANNINO FUN. HOME | | ADDRESS 257 S. CONKLING ST., BALTO., MD. | | 25a. REC'D BY REGISTRAR DATE NOV 19 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE  | |

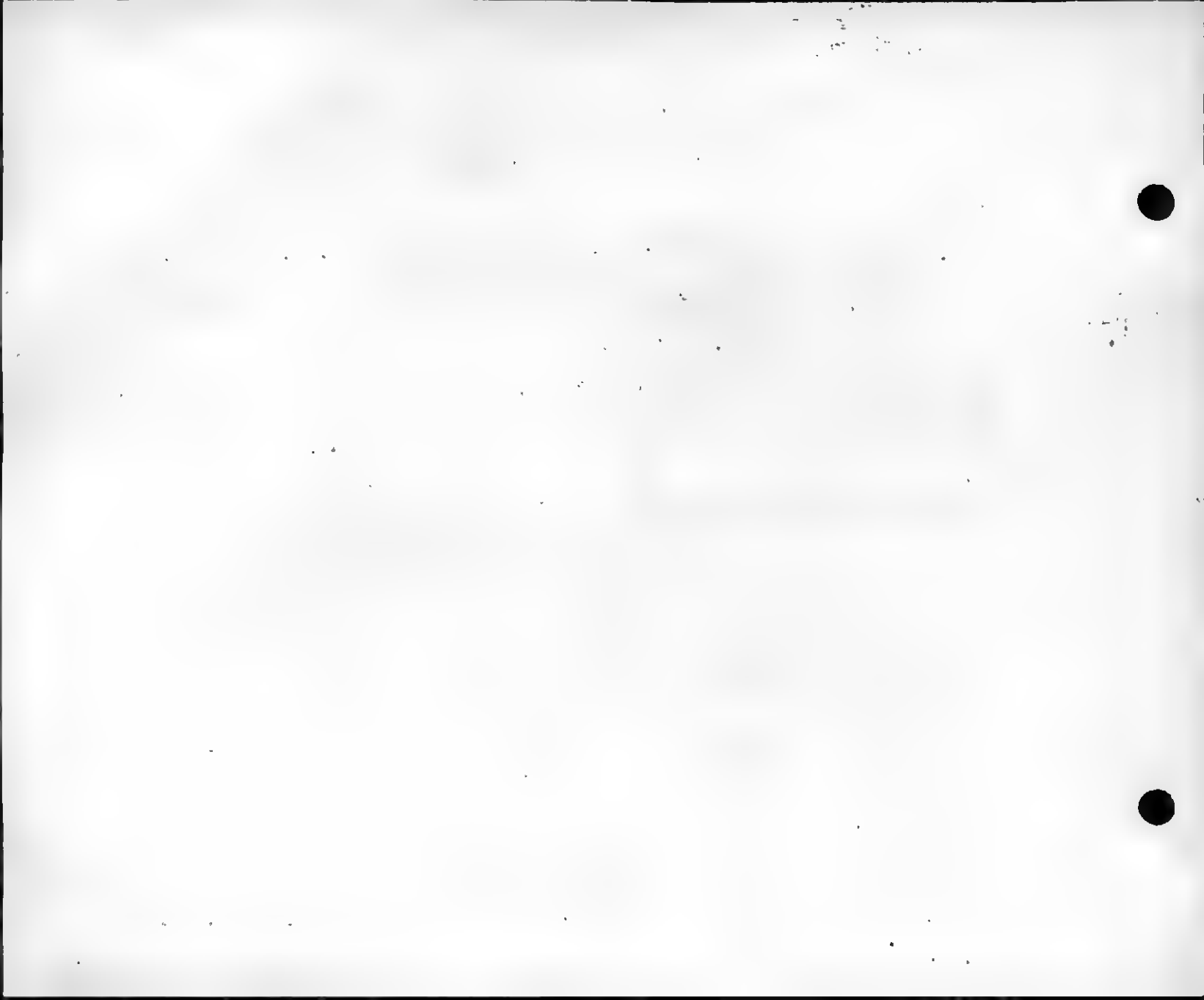


Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1x68

| <div style="display: flex; justify-content: space-between;"> 15651 <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div> 15665 </div> | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Marian A. Razmus</i> | | | | 2a. DATE OF DEATH Nov. Month <i>2</i> , Day <i>68</i> Year | | | | 2b. HOUR <i>2:30 AM</i> | | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>July 27, 1912</i> | | 6. AGE (In years last birthday) <i>56</i> YRS. | | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN _____ | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Minnesota</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Owings Mills</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>11 Ritters Lane</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Clerk at N. & P. Company</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Owings Mills</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>11 Ritters Lane</i> | | | | | |
| 14. FATHER'S NAME First <i>Harry</i> Middle <i>C.</i> Last <i>Beecher</i> | | | | 15. MOTHER'S M A DEN NAME First <i>Anna</i> Middle <i>Pickett</i> Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>368-01-1245</i> | | 17. INFORMANT Address <i>Mr. John P. Razmus Jr. Owings Mills, Md.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Carcinoma - pancreas</i> <i>1579</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (b) <i>Metastasis to colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>6 months</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1-1-1</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <i>19</i> P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>68</i> , to <i>November 2, 1968</i> , that (I) (we) lost saw the deceased alive on <i>November 2, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>C. E. McWilliams</i> | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>November 2, 1968</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS <i>11904 Reisterstown Rd Reisterstown Md</i> | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11/4/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Memorial</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Carroll Co. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>J. F. Feltline & Sons Reisterstown, Md</i> | | | | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 4 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |

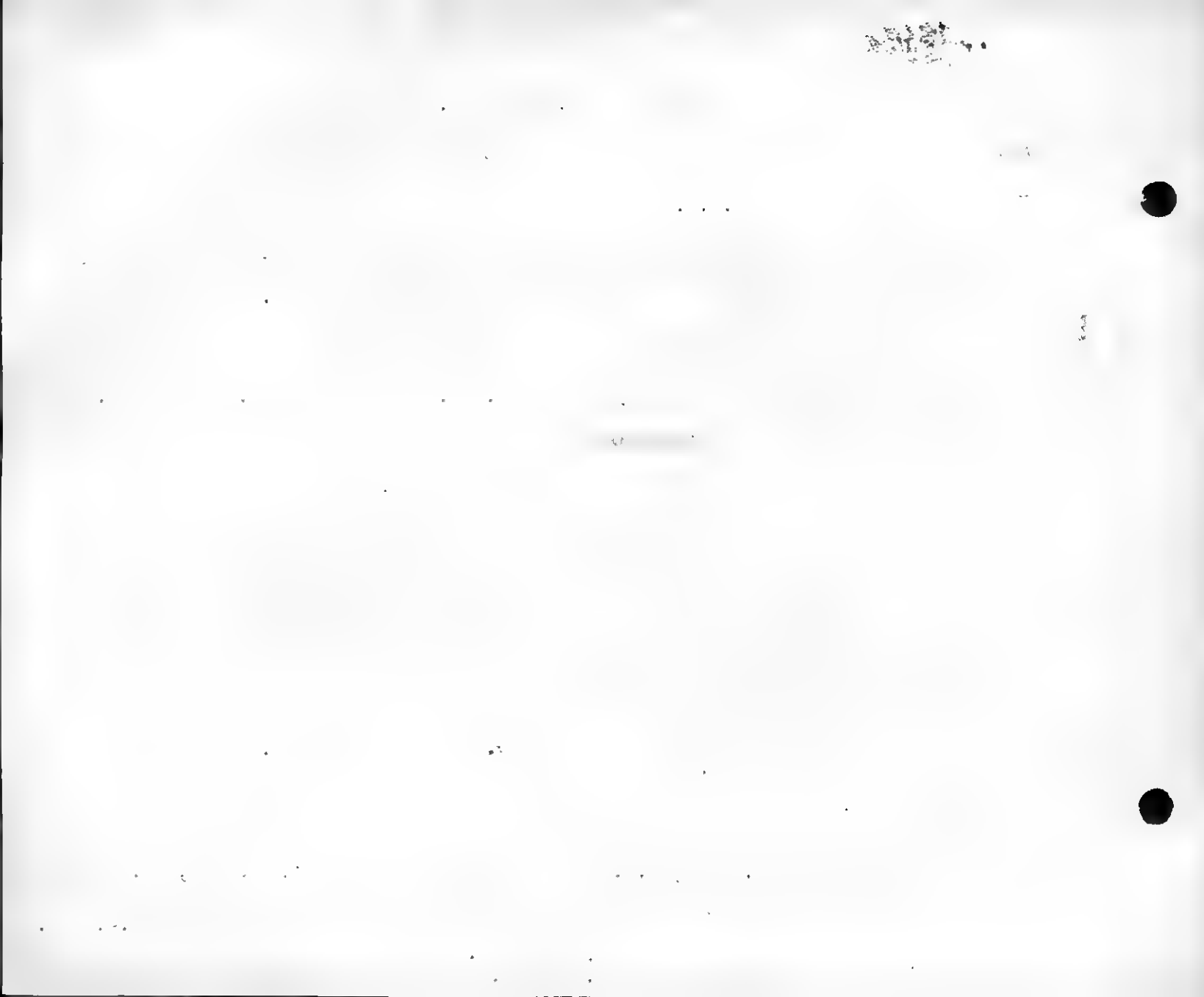


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in every event, within 72 hours after the death.

VR A15
45M - 1

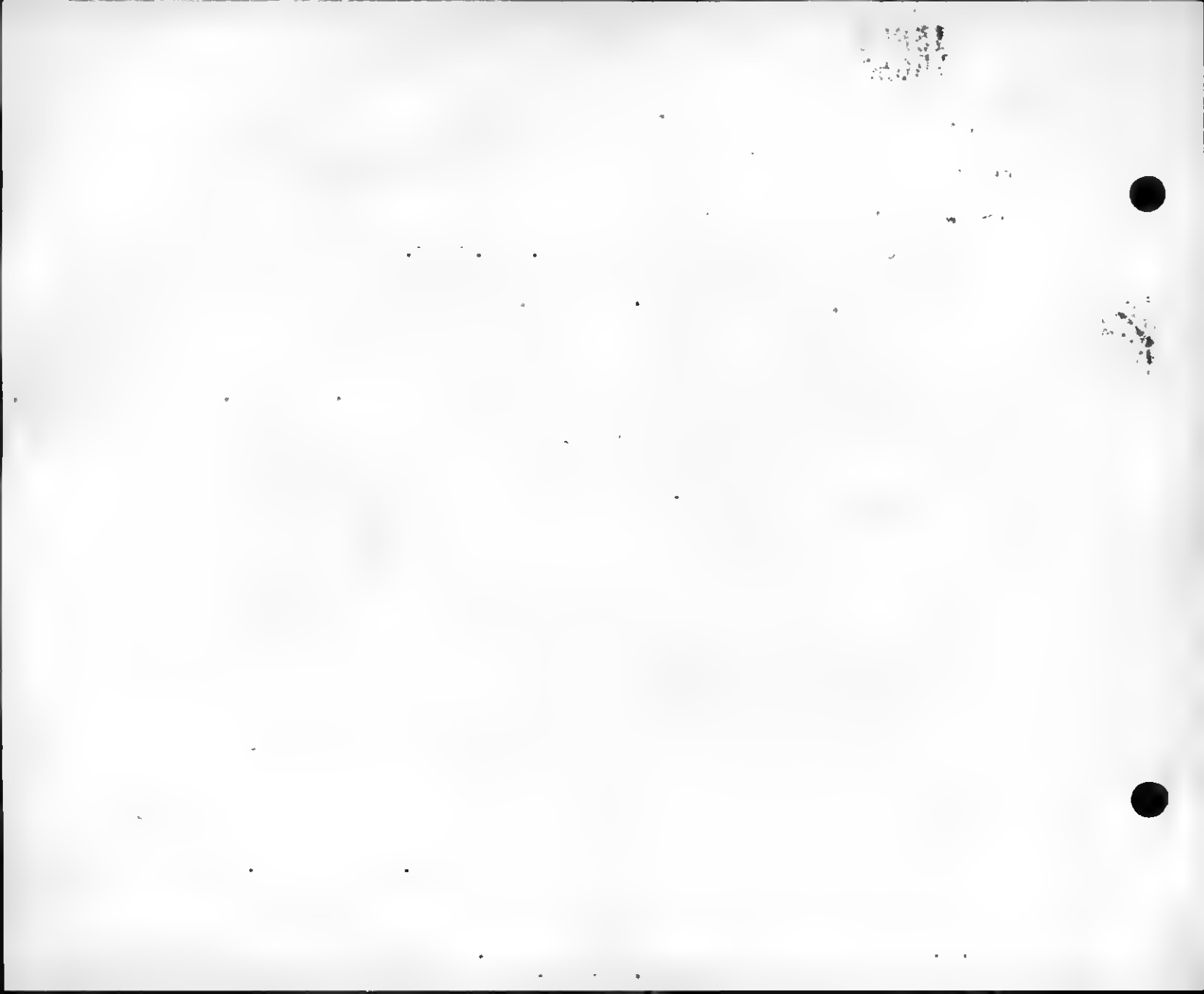
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) ARTHUR STANLEY REEDER SR. | | | 2a. DATE OF DEATH Month NOVEMBER Day 21 Year 1968 | | | 2b. HOUR 6:35 PM | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 1/8/95 | | 6 AGE (in years last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS 4 DAYS 1 | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH Fort Howard | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | 12b KIND OF BUSINESS OR INDUSTRY Steel | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 547 E. Gittings Street | |
| 14 FATHER'S NAME First AMAS Middle REEDER Last REEDER | | | 15 MOTHER'S MAIDEN NAME First Emma Middle Bristow Last Bristow | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give war or dates of service) WW I | | 16b SOCIAL SECURITY NO. 215 05 5340 | | 17 INFORMANT Address Clin. Rec. VA Hospital, Ft. Howard, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per ne for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 491X DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a) OBSTRUCTIVE PULMONARY EMPHYSEMA stating the underlying cause DUE TO OR AS A CONSEQUENCE OF last CHRONIC BRONCHITIS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS YEARS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No 18 City or Town Fort Howard County Baltimore State Md. | | | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 18 , 19 68 , to Nov. 21 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov. 21 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Rodolfo G. Miro | | DEGREE M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c DATE SIGNED 11/21/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RODOLFO G. MIRO, M.D. | | 22e. ADDRESS VA HOSPITAL, FORT HOWARD, MD. 21052 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 11-25-68 | | 23c NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d LOCATION (City or Town) (County) (State) Glen Burnie A.A. Md. | | | |
| 24 FUNERAL DIRECTOR McCully Funeral Home | | ADDRESS 130 E. Fort Ave. Balto. 30, Md. | | 25a REC'D BY REGISTRAR DATE NOV 25 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |



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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---------------------------|
| <div>15653</div> <div>Item 15 Filed 12/9/68 kk</div> <div>CERTIFICATE OF DEATH</div> <div>15667</div> | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last SARA M. REESE | | | | | 2a. DATE OF DEATH Month Day Year 11 30 68 | | | | | 2b. HOUR 3:55am |
| 3 SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH 7-25-1901 | | | 6. AGE (In years lost birthday) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cent. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Education | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | 13b. COUNTY Balto. Balto. 12 | | 13c. CITY OR TOWN Balto. 12 | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 102 Dunbarton Road | |
| 14. FATHER'S NAME First Middle Last George Reese | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sara Sayler Manly | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO 220-22-2578 | | 17. INFORMANT Address Richard Reese, 1164 E. Northern Pkwy. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure | | | | | | | | | | |
| <div>174x</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div> DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of breast with metastasis to lung DUE TO, OR AS A CONSEQUENCE OF (c) </div> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170x | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or RFD No. City or Town County State | | | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from 11-16 , 19 68 , to 11-30 , 19 68 , that (I) (we) last saw the deceased alive on 11-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Chang Lin, M.D. | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-30-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Chang Lin | | | | | 22e. ADDRESS 6701 N. Charles St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY Elkton | | 23d. LOCATION (City or Town) (County) (State) Elkton Md. | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR DEC 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Daniel Reichert Jr. asked for release of body.

| | | | | | |
|--|--|---|--|--|--|
| Items 1, 14 & 15 Filled | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 15668 | |
| 11/8/68 kk | | Item 1 taken from | | CERTIFICATE OF DEATH | |
| 1 DECEASED NAME (Type or print) Daniel Reichert Robert Reichert Sr. | | First Middle Last | | 2a. DATE OF DEATH 11 Month 02 Day 68 Year | |
| 3. SEX Male | | 4 RACE Cauc. | | 2b. HOUR 9:28 PM | |
| 5. DATE OF BIRTH Feb. 24, 1908 | | 6 AGE (In years last birthday) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Baltimore Co. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balto. Med. Cen. | | 9. COUNTY OF DEATH Baltimore Co. Md | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Sparks | |
| 13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER Yeoho Rd. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 14 FATHER'S NAME First Middle Last Frederick Reichert Reichert | | 15. MOTHER'S MAIDEN NAME First Middle Last Martha Walsh | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 212 30 5622 | | 17. INFORMANT Address Dan Reichert, Jr. Cockeysville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | |
| 16a0 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Hyperkalemia | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Renal blood flow obstruction with CA | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) of Trochea | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (this hospital) attended the deceased from Nov. 2, 1968, to Nov. 2, 1968, that (I) (we) last saw the deceased alive on Nov. 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED Nov. 03, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Manuel V. Gatchalian M.D. | | 22e. ADDRESS 6701 N. Charles St. | | 22f. CITY, STATE, AND ZIP CODE 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 6, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Jessops | |
| 23d. LOCATION (City or Town) Sparks, Baltimore, Md. | | 23e. COUNTY (County) Baltimore | | 23f. STATE (State) Md. | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR NOV 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1047

15665

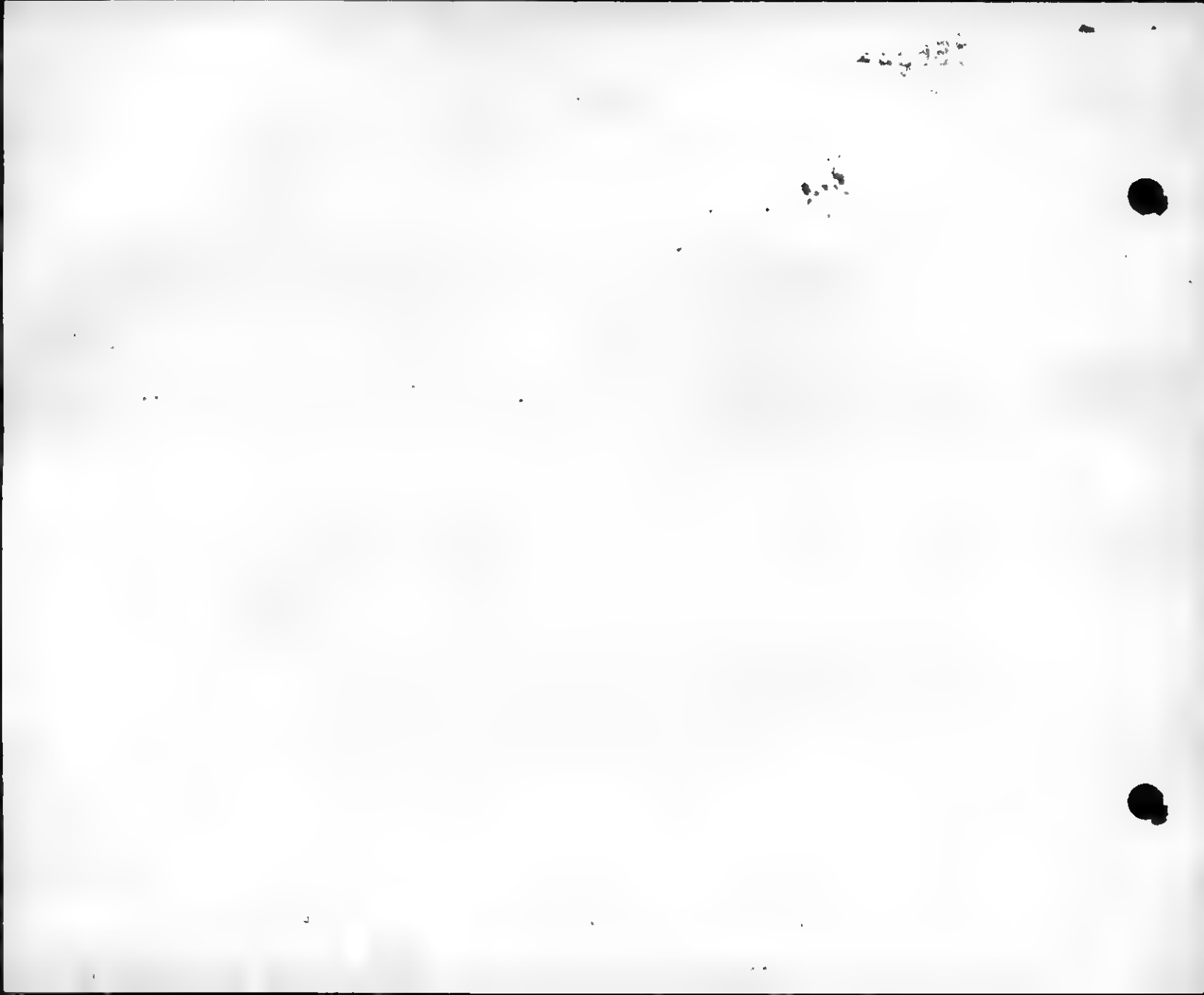
15669

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME (Type or print) Sonia | | | First Sonia Middle Latalie Last Richman | | | 2a. DATE OF DEATH 11 Month 4 Day 60 Year | | | 2b. HOUR 6:30 PM | | |
| 3 SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH 3-7-38 | | | 6 AGE (In years last birthday) 30 YRS. | | |
| 7a BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore County Md. | | |
| 10. CITY OR TOWN OF DEATH Landellstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calto Co Gen Hosp | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | | 12b KIND OF BUSINESS OR INDUSTRY AT HOME | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b COUNTY Calto | | | 13c CITY OR TOWN Owings Mills | | | 13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 14. FATHER'S NAME First BERNARD Middle KLEIN Last KLEIN | | | 15 MOTHER'S MAIDEN NAME First ANNA Middle ROSENBLUM Last ROSENBLUM | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | 16b SOCIAL SECURITY NO | | |
| 17 INFORMANT Address MR. HARRY RICHMAN, #6 WESTGATE CT., OWINGS MILLS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETIC COMA. ? Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) hours ? YRS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diffuse pulmonary edema & congestion | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-4 , 19 68 , to 11-5 , 19 68 , that (I) (we) last saw the deceased alive on 11-4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Simon Calle, MD | | | DEGREE MD | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 11-5-68 | | |
| 22d. PHYSICIAN'S NAME (Type) SIMON CALLE | | | 22e. ADDRESS | | | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 23b DATE 11-6-68 | | | 23c. NAME OF CEMETERY OR CREMATORY HAHAVASH SHALOM | | | 23d LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | ADDRESS | | | 25a REC'D BY REGISTRAR NOV 8 1968 | | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2c. DATE OF DEATH | | 2b. HOUR | |
| Ida | | | Ridgway | | | Nov. Month 27, Day 68 Year | | 4:30 P.M. | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| F.M. | | White | | Jan. 9, 1901 | | 67 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 12b K.IND OF BUSINESS OR INDUSTRY | |
| Maryland | | U.S.A. | | | | Baltimore | | May Co. Store | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b K.IND OF BUSINESS OR INDUSTRY | |
| Randallstown | | | 9322 Liberty Road | | | Assi. Buyer | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY - Y.N.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md. | | | Balto. | | | Randallstown | | 9322 Liberty Road 21133 | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Alpheus J. Ross | | | Jessie Litchfield | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or (unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | |
| no | | | 215-22-7437 | | Gordon E. Biddinger McDonough Rd. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of uterus - generalized metastases</u> | | | | | | | | | 15 Months |
| 1829 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 117 | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21c LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 10/16, 1964, to 11/27, 1968, that (I) (we) last saw the deceased alive on 11/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (did not) view the body after death. | | 22b SIGNATURE <u>Edwin L. Pierpont, M.D.</u> DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED 11/27/68 | | | |
| 22d PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u> | | 22e ADDRESS <u>8204 LIBERTY RD. - BALTO. 21201 MD</u> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | Nov. 29, 1968 | | Cedar Hill | | Glen Burnie Md. | | | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Loring Byers Funeral Service 8728 Liberty Rd. | | | | DATE DEC 2 1968 | | <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

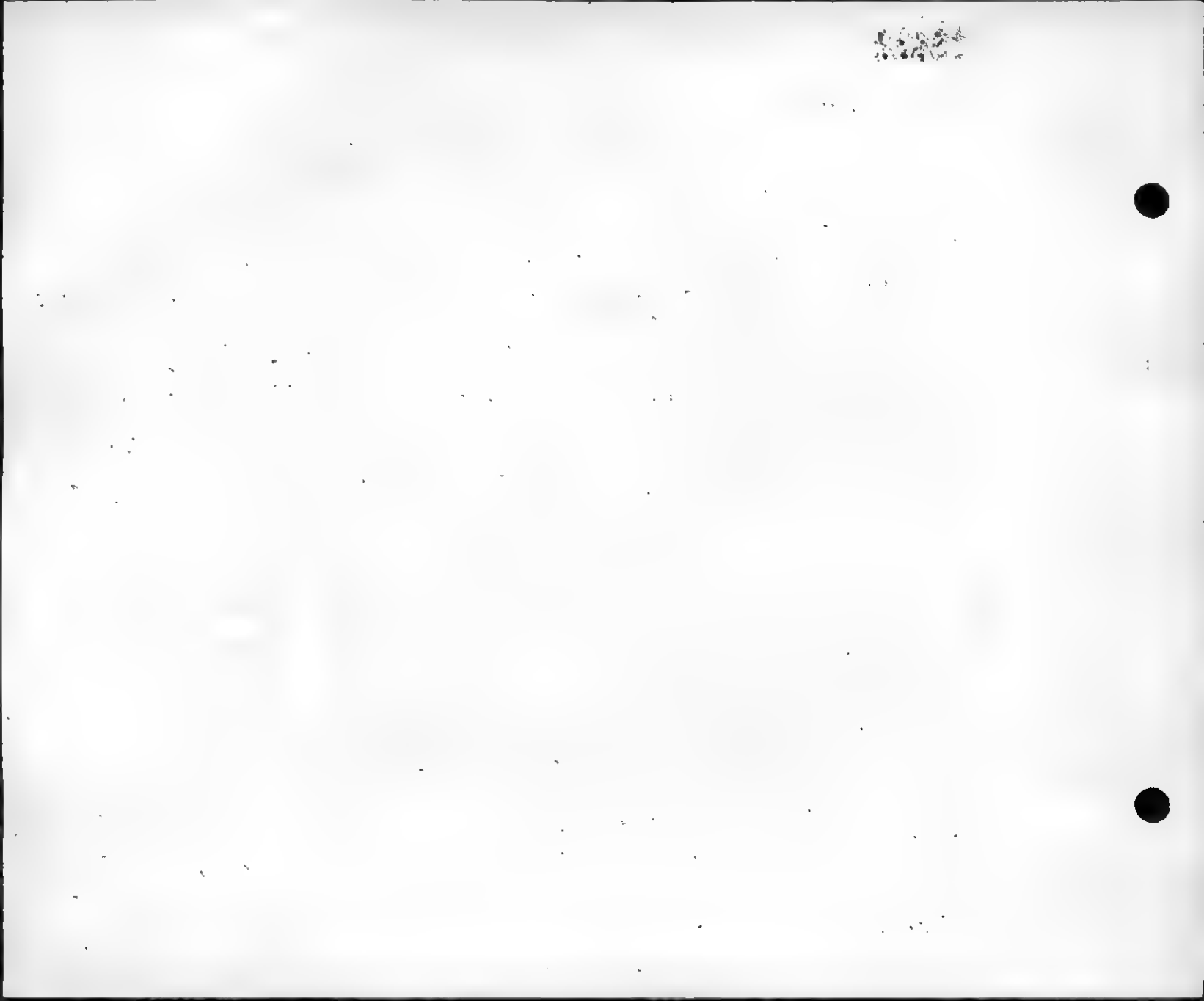
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15671

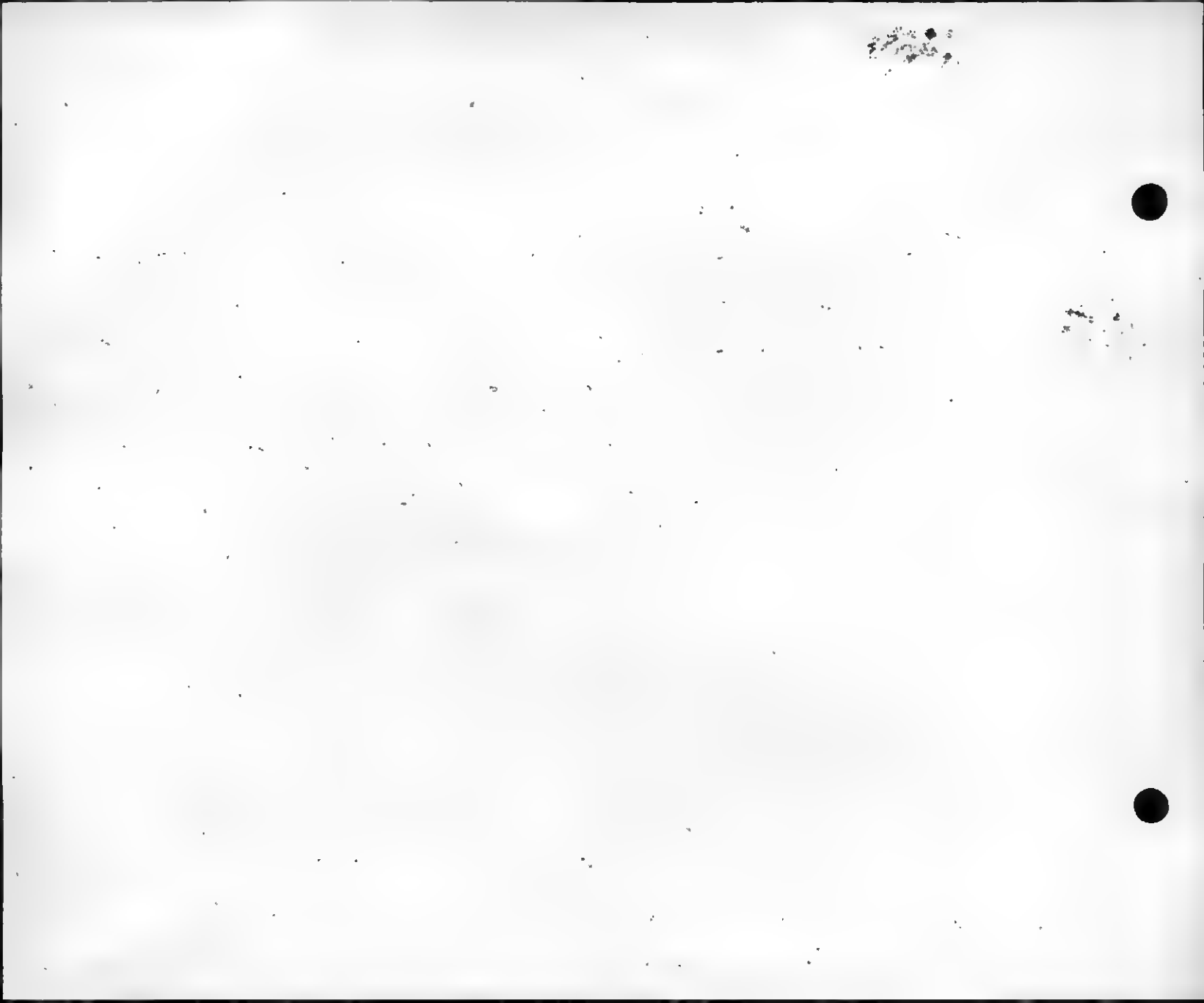
| | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <u>James</u> First <u>Roe</u> Middle Last | | | 2a. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1968</u> | | | 2b. HOUR <u>11:41 P.M.</u> | | | |
| 3 SEX <u>Male</u> | | 4 RACE <u>White</u> | | 5. DATE OF BIRTH <u>Dec 19, 1871</u> | | 6 AGE (In years last birthday) <u>96</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Baltimore</u> Md. | | | |
| 10 CITY OR TOWN OF DEATH <u>Dundalk</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>BALTIMORE HOSPITAL</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>CARPENTER</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MD.</u> | | 13b. COUNTY <u>BALTIMORE</u> | | 13c. CITY OR TOWN <u>DUNDALK</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>117 BALTIMORE AVE</u> | |
| 14. FATHER'S NAME First <u>LEVI D.</u> Middle <u>ROE</u> Last | | | 15. MOTHER'S MAIDEN NAME First <u>FANNIE</u> Middle <u>CACOPER</u> Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (not or unknown) <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>LINKED</u> | | 17 INFORMANT <u>ROSE BROOKINS, BALTIMORE, MD</u> | | Address <u>BALTIMORE AVE</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>41</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1958</u> , to <u>NOV 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>NOV 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>David H. Andrew MD</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>11/17/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>David H. Andrew MD</u> | | | | 22e. ADDRESS <u>322 Kernway Balto. Md 21212</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>11/19/1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>OXFORD</u> | | 23d. LOCATION (City or Town) (County) (State) <u>OXFORD MD</u> | | | |
| 24. FUNERAL DIRECTOR <u>THURICE T. NATHANSON, EASTON, MD</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>NOV 19 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



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| <div>4</div> <div>1</div> <div>15658</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> <div>15672</div> | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last Julian M. Rogers | | | | | 2a. DATE OF DEATH 11 Month 28 Day 68 Year | | | 2b. HOUR 2:30 PM | | |
| 3 SEX M | | 4. RACE W | | 5. DATE OF BIRTH 1-25-1877 | | | 6. AGE (In years last birthday) 91 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) Leesburg, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 406 Patleigh Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) V.P. Amer. Bank Stationery-Ret'd | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland Patleigh Road | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 406 Patleigh Road | |
| 14. FATHER'S NAME First Middle Last Alexander Hamilton Rogers | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Julia Clagett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO 216-09-9916 | | 17. INFORMANT Address AMrs. Julian M. Rogers Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sen. arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years years | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Manuel J. Rodriguez</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 11-29-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Manuel J. Rodriguez | | | | | | 22e. ADDRESS 1424 Sulphur Spring Road | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City or Town) (County) (State) Leesburg, Va. | | | |
| 24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4005 York Road Balto., Md. | | | | | | 25a. REC'D BY REGISTRAR DEC 2 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

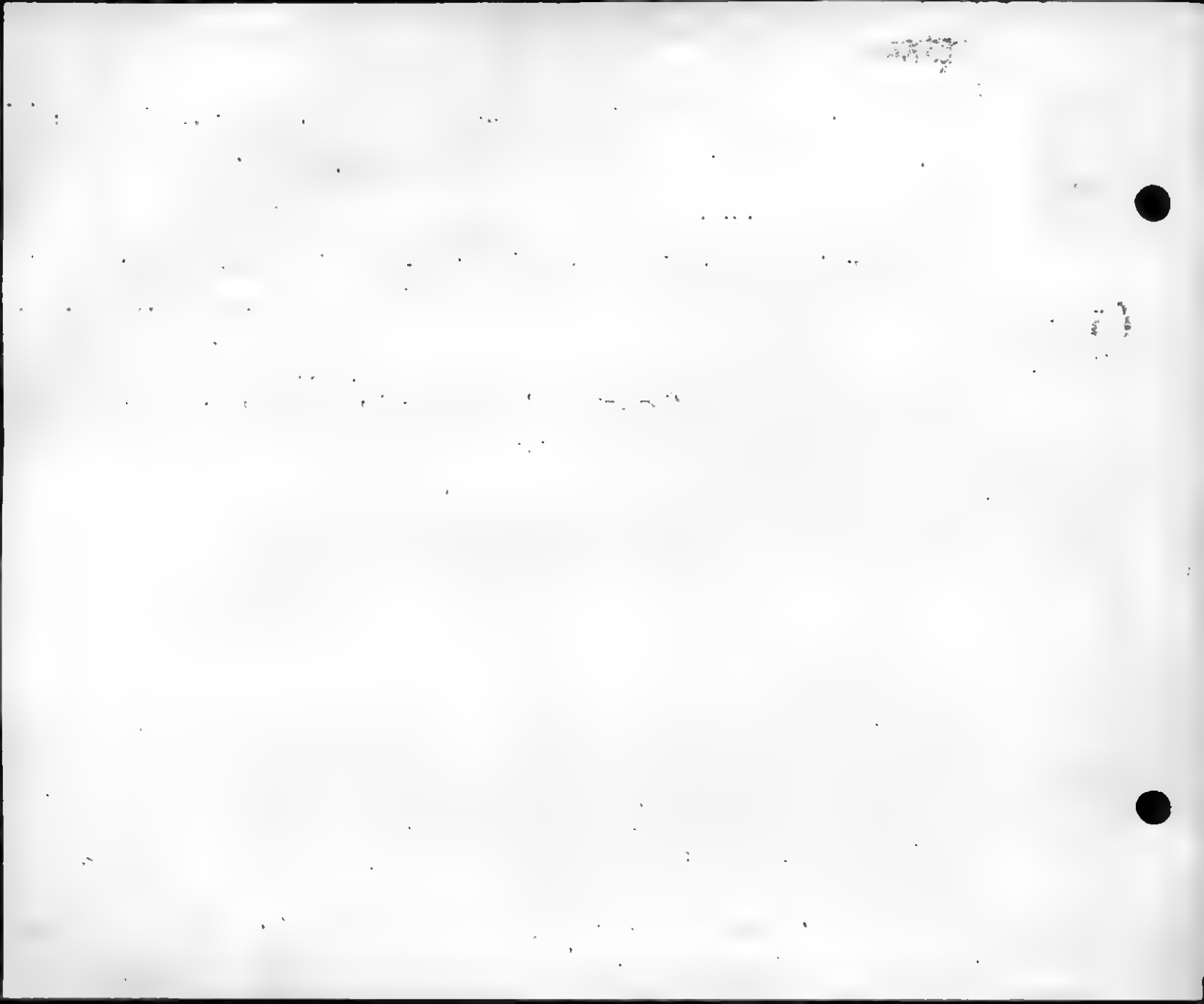


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| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|---|--|---|---|---|---|--|
| 15659 | | 15673 | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| BLANCHE | | | IRENE | ROSE | NOV. 7th, 1968 | | | 1:45 P.M. | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (n years last birthday) | | F UNDER 1 YEAR | |
| FEMALE | | WHITE | | OCTOBER 19th, 1882 | | 86 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Pittsburg, Penna | | U.S.A. | | | | Baltimore County | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Lutherville, Maryland | | | College Manor, Nursing Home | | | Owner of Business | | Dry Cleaning | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e STREET AND NUMBER | | | |
| First Middle Last | | | First Middle Last | | | Wyman Park Apts., Balto., Md. | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT (Step-Daughter) | | Address | |
| no | | | 216-05-5379 | | | Mrs Reuben Maurv. Westport, Connecticut | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 440.7 DUE TO, OR AS A CONSEQUENCE OF (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967 to Nov 7, 1968, that (I) (we) last saw the deceased alive on 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE (Signature) M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c. DATE SIGNED 11-7-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Wm. G. Helfrich | | | | | 22e. ADDRESS 5006 Roland Ave. Balto, Md. | | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | 11-9-1968 | | Greenmount Cemetery | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR (Signature) Wm. Cook-Brooks, Inc. 1417 S. Paul St. Balto, Md. | | | | | 25a REC'D BY REGISTRAR DATE NOV 12 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

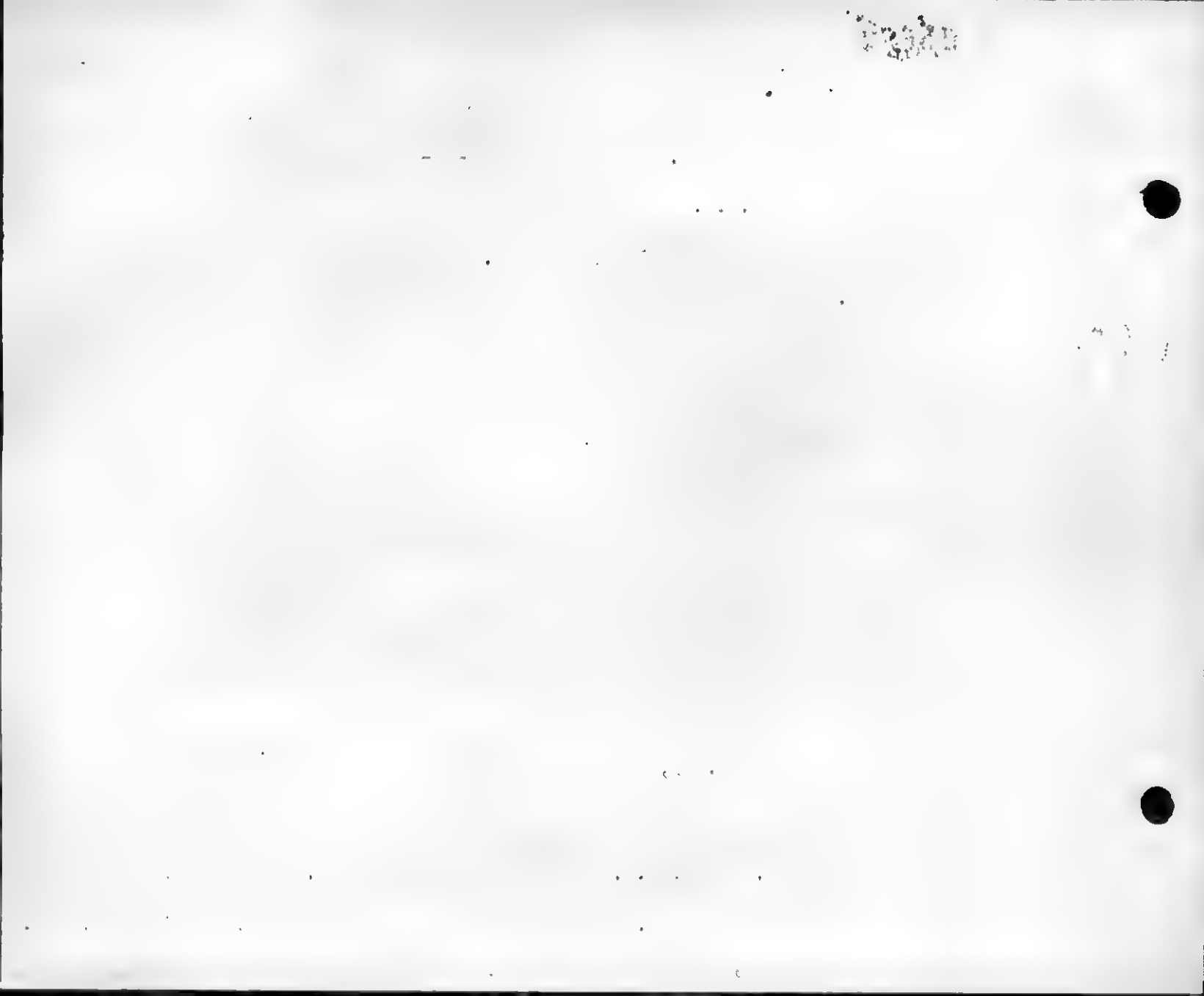
| 15660 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15674 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last Leah NMI Rosen | | | | | | | | | | Month Day Year November 16, 1968 | | | | | | | | | | 10:40 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX XFEMALE | | | | | | | | | | 4. RACE WHITE | | | | | | | | | | 5. DATE OF BIRTH 9- -95 | | | | | | | | | | 6. AGE (In years last birthday) 73 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Baltimore. | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. Gen. Hosp. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) HOUSEWIFE | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Balto. | | | | | | | | | | 13c. CITY OR TOWN Randallstown | | | | | | | | | | 13d. INSIDE CITY LIMITS? NO | | | | | | | | | | 13e. STREET AND NUMBER 6800 Liberty Road | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last NATHAN LIBOWITZ | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rosa ROSE ? | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | | | | | | | | 17. INFORMANT MR. HILLARD GAMERMAN, 6825 PIMLICO DR. #9 | | | | | | | | | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Pulmonary edema - severe</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>weeks</u> <u>years</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>42</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | | | | | | 21e. PLACE OF INJURY (At HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> , 19 <u>68</u> , to <u>11-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Angelita Toppas</u> | | | | | | | | | | 22c. PHYSICIAN'S NAME (Type) ANGELITA TOPPAS | | | | | | | | | | 22d. ADDRESS BETH | | | | | | | | | | 22e. DATE SIGNED 11-16-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | | 23b. DATE 11-18-68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY ADATH JESHURUN | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Sal Levinson & Bruce Rabinowitz</u> | | | | | | | | | | 25a. REC'D BY REG STRAR NOV 20 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Monica J. Jones</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|----------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 17214 | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Teresa | | | Middle Rudiger | | | Last | | | 2a. DATE OF DEATH Month 11 Day 29 Year 1968 | | | 2b. HOUR M | | |
| 3. SEX Female | | | 4. RACE Cau. | | | 5. DATE OF BIRTH 9-12-1906 | | | 6. AGE (In years last birthday) 62 YRS. | | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4247 Darleigh Rd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 4247 Darleigh Road 36 | | | | | | | | |
| 14. FATHER'S NAME First Nicholas Middle Spartana Last | | | 15. MOTHER'S MAIDEN NAME First Genevieve Middle Russo Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Carcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months 1964 | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19 Nov. 29 , 19 68 , that (I) (we) last saw the deceased alive on Nov. 29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Harold H. Burns M.D. | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Harold H. Burns, M.D. | | | 22e. ADDRESS 8106 Harford Rd., Baltimore, Md. 21234 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 12/2/68 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Fullerton, Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home, 7401 Belair Road 21236 | | | ADDRESS | | | 25a. REC'D BY REGISTRAR DEC 23 1968 | | | 25b. REGISTRAR'S SIGNATURE William J. Jones | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15662

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1567.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--------|-------------------|--|--|--------------------------------|--|--|----------------|-------------------|--|--|--|--|--|-------------------------------------|--|--|--|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | | | | | |
| BRADFORD | | | Lane | | | SAVAGE | | | 11 19 1968 | | | M | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | |
| Male | | White | | Dec. 20, 1921 | | 46 YRS | | MONTHS DAYS HOURS MIN. | | November 19, 1968 | | M | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| North Carolina | | | | U.S.A. | | | | | | | | Baltimore Co. Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Owings Mills | | | | 34 Featherbed Lane | | | | Attendant | | | | Gas station | | | | | | | |
| 13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Baltimore | | | | Owings Mills | | | | 34 Featherbed Lane | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Graham | | | | Savage | | | | Mattie | | | | Anna Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| Yes | | | | WW II | | | | 238-28-9001 | | | | Mrs. Carolyn Savage | | | | 34 Featherbed La. Owings Mills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | | | |
| 4129 | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 4129 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| CAUSE OF DEATH | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No | | | | City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) | | | | Edward F. Wilson, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | November 20, 1968 | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | Nov. 22, 1968 | | | | Baltimore National Cem. | | | | Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| H. J. Ehrhardt | | | | Owings Mills, Md. | | | | NOV 22 1968 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div> <div>Film 407 Item 18 11-26-68, MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>15663</div> <div>CERTIFICATE OF DEATH</div> <div>15676</div> </div> | | | | | | | | | | | |
|--|--|---|---|--|--|---|---|--|-----------------------------------|--|----------------------------|
| 1 DECEASED NAME (Type or print) First Middle Last William Schamehorn | | | | | | 2a DATE OF DEATH Month Day Year Nov 16 1968 | | | 2b HOUR 12 N | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH 1-5-98 | | | 6 AGE (In years last birthday) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Mary | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | Md | | |
| 10. CITY OR TOWN OF DEATH Carrison | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foxleigh | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE md | | | | 13b COUNTY Baltimore | | 13c US-DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 3223 + 1007 St. | | | |
| 14 FATHER'S NAME First Middle Last Joel Schamehorn | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lisa Dunbar | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | | 16b. SOCIAL SECURITY NO 217-01-5322A | | 17 INFORMANT Address Marguerite Schamehorn | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Colon by History</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 153.2 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-4, 1968, to 11-16, 1968, that (I) (we) last saw the deceased alive on 11-15, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE David I. Miller | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11-16-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) David I. Miller | | 22e. ADDRESS 9115 Reisterstown Rd. | | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE 11/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | | 23d. LOCATION (City or Town) (County) (State) Balto. City, Md. | | | | |
| 24. FUNERAL DIRECTOR Cort Brooks | | | | | | 1217 ST. E ST Baltimore, Md. | | 25a. REC'D BY REGISTRAR DATE NOV 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

222

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
3044 REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|---|--|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| [REDACTED] | | | SARA G. Scherr | | | NOVEMBER 12 1968 | | 10 19 PM | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | 3/29/05 | | 63 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md | | U.S.A. | | | | Baltimore Md. | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Randallstown | | | Baltimore County Hosp | | | SALESGIRL | | RETAIL | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| STATE Baltimore COUNTY Balto. | | | Balto | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3830 Beehler Ave. | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JOSEPH SCHERR | | | FANNIE LIPMAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT Address | | | |
| NO | | | | | | MRS. GOLDIE WEINBERG, 3906 LABYRINTH RD. #15 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Ventric fibrillation | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) myocardial infarction following | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) diaphragmatic hernia repair | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. ALTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 11/12/68 | | large diaphragmatic hernia | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f LOCAT ON | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or RFD No | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21/1968, to 11/12/1968, that (I) (we) last saw the deceased alive on 11/12/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | 22c. DATE SIGNED | | 22d PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| [Signature] | | 11/12/68 | | Samuel J. Abrams | | 7220 Park Heights Ave | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 11-14-68 | | PROGRESSIVE SICK & RELIEF | | ROSEDALE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | DATE NOV 14 1968 | | [Signature] | | | |

1994



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1567

15663

| | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|---------|--|
| 1. DECEASED-NAME (Type or print) Schiaffino, Mrs. Rosalie L. | | | 2a. DATE OF DEATH Month Nov. Day 17 Year 1968 | | | 2b. HOUR 8 A M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 11/20/1883 | | 6. AGE (In years last birthday) 84 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | 3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 723 Springfield Ave. | | | |
| 14. FATHER'S NAME First Middle Last Jean B. Retz | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rosalie Jaxel Bena | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 215-07-5204-D | | 17. INFORMANT Hospice Records | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral artery disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/68 , 19____, to 11/17/68 , 19____, that (I) (we) lost saw the deceased alive on 11/15/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/17/68 | | |
| 22d. PHYSICIAN'S NAME (Type) [Signature] | | | | | | 22e. ADDRESS Stella Maris Hospice | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/20/68. | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

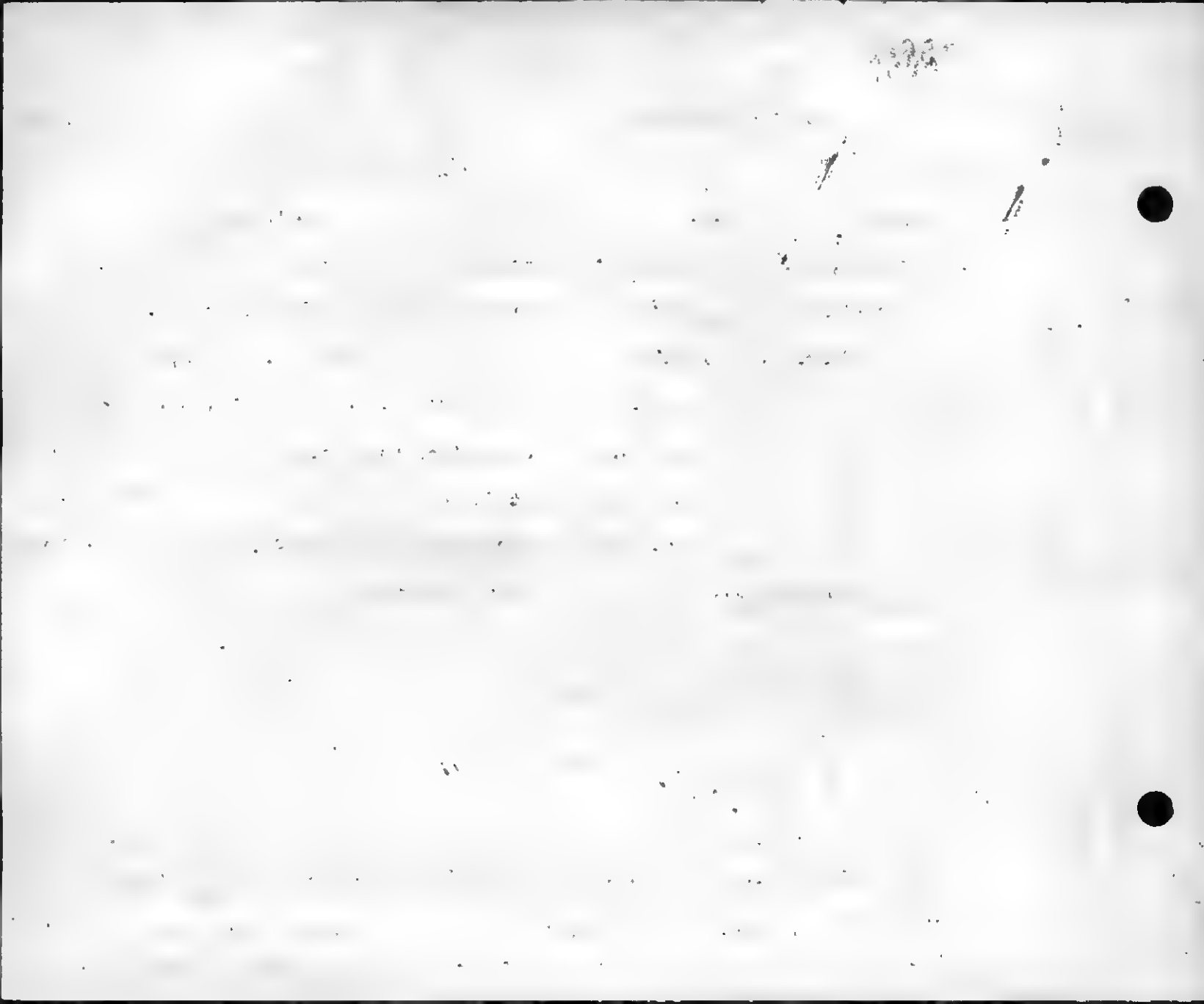
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| 15666 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15679 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| First Middle Last Jo Ann Schindler | | | | | | | | | | Month Day Year 11 9 68 | | | | | | | | | | 8:45P M | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH 5/3/68 | | | | | | | | | | 6. AGE (In years last birthday) 6 6 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Balto. City Maryland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Owings Mill, Md. | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY City | | | | | | | | | | 13c. CITY OR TOWN Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Edward N. Schindler | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rita K. Murphy | | | | | | | | | | 13e. STREET AND NUMBER 6309 Brown Ave. | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. None | | | | | | | | | | 17. INFORMANT Address 6309 Brown Ave. Baltimore, Md. 21224 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute passive Congestion Pulmonary | | | | | | | | | | | | | | | | | | | | Terminal | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Congestive Heart Failure | | | | | | | | | | | | | | | | | | | | Terminal | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Encephalopathy Congenital, Hydranencephaly | | | | | | | | | | | | | | | | | | | | 6 Mos. 6 dys | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Meningoencephalitis 3 months prior to death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 Oct , 19 68 , to 9 Nov , 19 68 , that (I) (we) last saw the deceased alive on 9 Nov , 19 68 , and that in (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard A. Jones</i> | | | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 10 Nov. 68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Richard A. Jones M.D. | | | | | | | | | | 22e. ADDRESS Carroll County General Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE 11/11/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Paula Funeral Home | | | | | | | | | | ADDRESS 1115 S. 1st St. | | | | | | | | | | 25a. REC'D BY REGISTRAR NOV 13 1968 | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | | | | | | | | | | | | | | | | | |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15667

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|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) Benjamin | | First Schrenker | | Middle Schrenker | | Last Schrenker | | 2a. DATE OF DEATH Month 11 Day 28 Year 1968 | | 2b. HOUR 11 | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH 1-6-1893 | | 6. AGE (In years last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS 75 DAYS 75 | | IF UNDER 24 HRS. HOURS 75 MIN. 75 | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH Fullerton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3800 Putty Hill Ave | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Selfemploy | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Fullerton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 21236 | | 13f. STREET AND NUMBER 3800 Putty Hill Ave | |
| 14. FATHER'S NAME First Benjamin | | Middle Schrenker | | Last Schrenker | | 15. MOTHER'S MAIDEN NAME First Catherine | | Middle Braun | | Last Braun | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes | | 16b. SOCIAL SECURITY NO W.W.1 | | 17. INFORMANT Edward B. Schrenker | | Address 3800 Putty Hill Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion c Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4201 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 4201 | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 4201 | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 4201 | | | | | | | |
| 21d. N.JURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, DESK, BUILDING, ETC) 4201 | | 21f. LOCATION Street or R.F.D. No 4201 | | City or Town 4201 | | County 4201 | | State 4201 | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1956 to Nov 1968 , that (I) (we) last saw the deceased alive on Nov 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death 4201 | | | | | | | | | | | |
| 22b. SIGNATURE Dr. F. T. Kasir | | DEGREE MD | | ATTENDING PHYS <input checked="" type="checkbox"/> | | MED DIRECTOR <input type="checkbox"/> | | STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11/30/68 | |
| 22d. PHYSICIAN'S NAME (Type) F. T. KASIR JR. | | 22e. ADDRESS 9005 HANFORD RD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-2-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood cemetery | | 23d. LOCATION (City or Town) Baltimore | | (County) Co. | | (State) Md | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 | | | | | | ADDRESS elair 21236 | | 25a. REC'D BY REGISTRAR DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE Richard J. Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

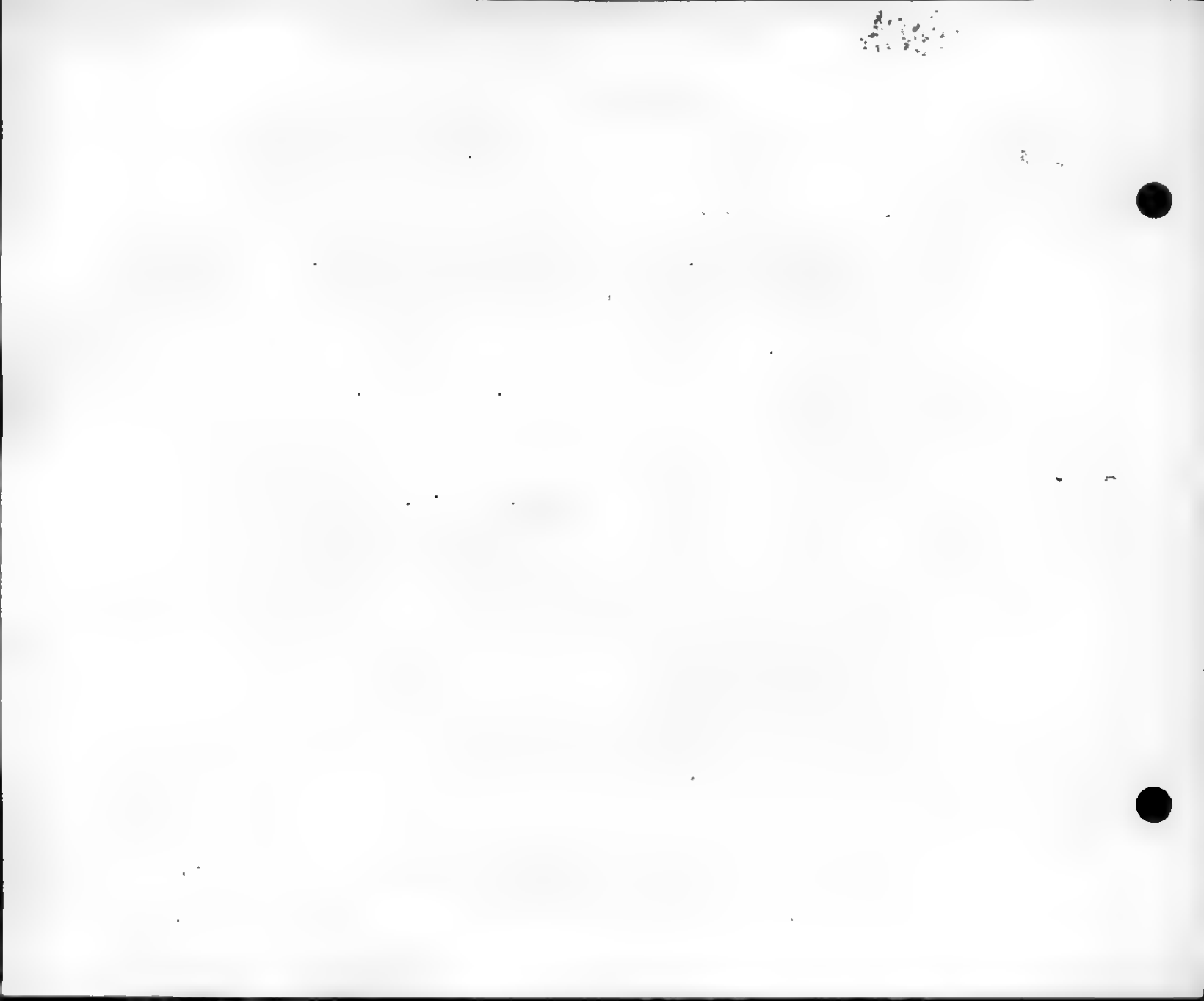
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15668

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15668

| | | | | | | | | | | | | |
|--|--|--|--|--|--|---|---|---|--|--|--|--|
| 1 DECEASED NAME (Type or print) | | First A | | Middle Marguerite | | Last SCOTT | | 2a. DATE OF DEATH Month 11 Day 22 Year 1968 | | | 2b. HOUR 9 A.M. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH January 9, 1897 | | | 6. AGE (In years last birthday) 71 YRS | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Cockeysville | | 13d. INS-DE CITY LIM-157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 613 Crambrook Rd. | | | | |
| 14 FATHER'S NAME First Middle Last Henry C. Schmidt | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Katherine Bendewald | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 217-03-2800D | | 17 INFORMANT Mrs. Dorothea K. Everitt, Same as # 13 | | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis acute 5621 DUE TO, OR AS A CONSEQUENCE OF (b) Diverticulitis with abscess formation and perforation DUE TO, OR AS A CONSEQUENCE OF last 5721 (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple abscesses in liver and brain | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that A (this hospital) attended the deceased from 11/15/ , 19 68 , to 11/22/ , 19 68 , that A (we) last saw the deceased alive on 11/22/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Samuel C. H. Lee, M.D. | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/22/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 25, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Pikesville, Md. | | | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. | | ADDRESS 1050 York Road Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR Nov 25 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |



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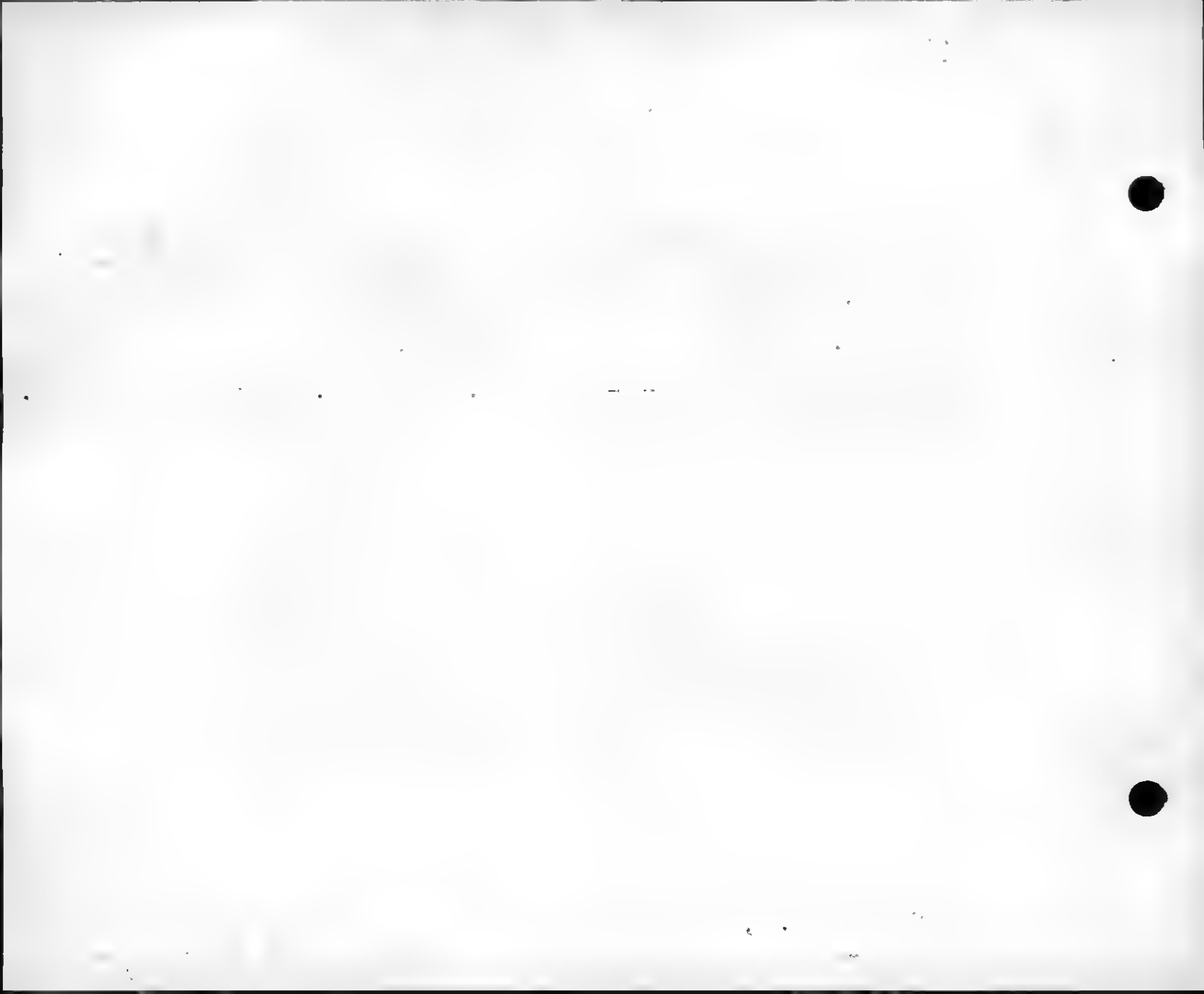
VR A154
30M REV. 7-68

15668

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1568

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME (Type or print) Robert First Robert Middle L. Last Sellers | | | 2a. DATE OF DEATH 11 Month 4 Day 68 Year | | | 2b. HOUR 12:10 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 3-22-13 | | 6. AGE (In years lost birthday) 55 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Principal #26 School | | 12b. KIND OF BUSINESS OR INDUSTRY Balto City | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 814 Charnel Dr. | | 14. FATHER'S NAME First Aethell E. Middle Sellers Last Sellers | | 15. MOTHER'S MAIDEN NAME First Nellie A. Middle Smardon Last Smardon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 217-03-8243 | | 17. INFORMANT Mrs. Elizabeth D. Sellers | | Address 8314 Charnel Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 7109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4201 (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Had 2 previous Myocardial Infarctions | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3-68 , 19 68 , to 11-4-68 , 19 68 , that (I) (we) last saw the deceased alive on 11-4-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE G. Kearforn, MD | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-4-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Nov. 7, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION (City or Town) (County) (State) Baltimore City Maryland | |
| 24. FUNERAL DIRECTOR Loring Byers | | ADDRESS 8728 Liberty Road Randallstown | | 25a. REC'D BY REGISTRAR NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



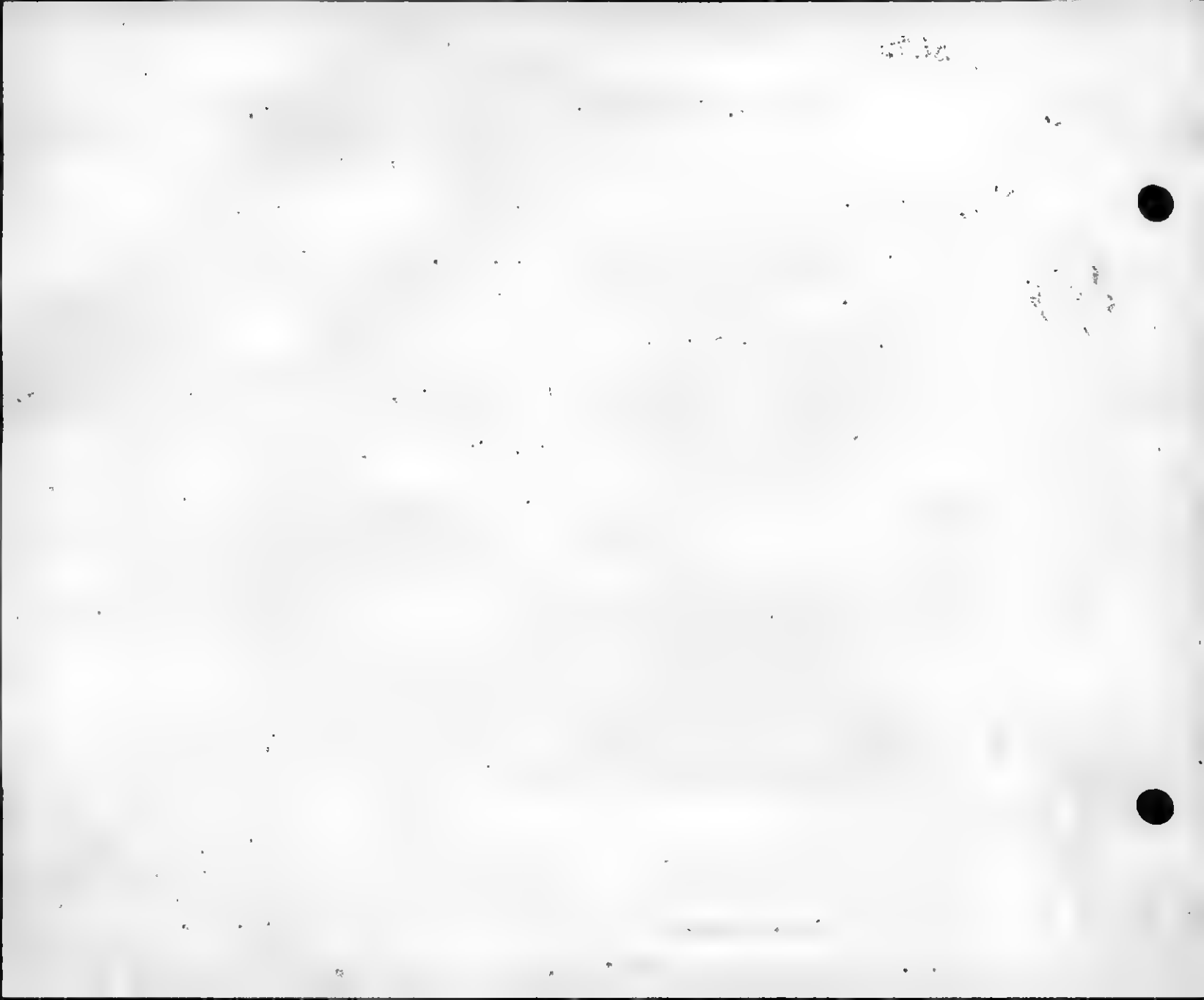
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CERTIFICATE OF DEATH

15684

| | | | | | | | |
|--|------------------------------|--|---|--|-----------------------------------|---|--|
| 1 DECEASED NAME (Type or print) | | First Middle Last | | 2a DATE OF DEATH | | 2b HOUR | |
| HOWARD W. SHAMLEFFER | | | | Nov. 24 Day 68 Year | | M | |
| 3 SEX | M | 4 RACE | W | 5. DATE OF BIRTH | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| | | | | Sept 11, 1888 | 80 YRS | | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | |
| Baltimore | 2189 | | | | Balto. Md | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Towson | | 8317 Ridgely Oak Rd. | | Retired | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | 13b COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER | | |
| Md. | | Baltimore | Towson | | 8317 Ridgely Oak Road | | |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | |
| Cornelius Shamleffer | | | Wells | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO (If yes give war or dates of service) | | 17 INFORMANT | | Address | |
| | | 216-28-0794 | | Daughter | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic EVD c Myocardial infarction</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis & Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5yr 10yr |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>12 Nov</u> , 19 <u>67</u> , to <u>24 Nov</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>20 Nov</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED | |
| | | | | | | 25 Nov 68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| | | 8604 Harford Rd Balto Md 34 | | | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | Nov. 26, 68 | | Balto | | Balto. Md. | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| P.A. Heemann | | 6067 Harford Rd. | | DEC 2 1968 | | J. Charles Judge | |



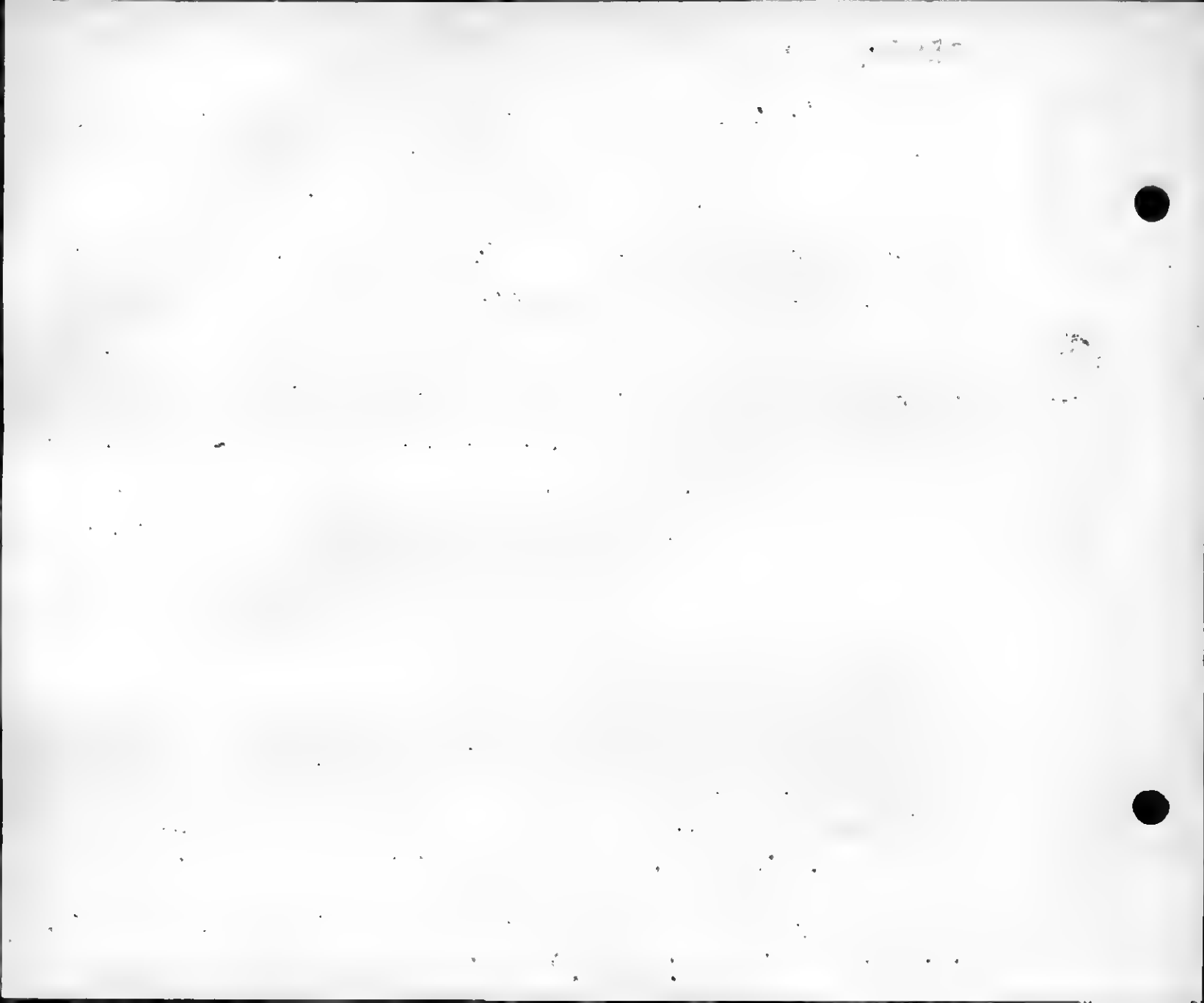
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VR A15 (4)
30M REV. 1/66

| <div style="display: flex; justify-content: space-between;"> 15670 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15684 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|---|--|--|--|---|------------------------------------|--|---|--|--|---|------------------------------|
| 1. DECEASED-NAME (Type or print) <i>Sadye Clendenin Shinnick</i> | | | | | | 2a. DATE OF DEATH Month <i>Nov</i> Day <i>10</i> Year <i>1968</i> | | | 2b. HOUR <i>6:15P M</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Cauc</i> | | 5. DATE OF BIRTH <i>12-14-86</i> | | | 6. AGE (In years last birthday) <i>81</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md | | | | | |
| 10. CITY OR TOWN OF DEATH <i>CATONSVILLE</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shangri-La Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOME-MAKER</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>TOWSON</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>7109 Sheffield Road</i> | | |
| 14. FATHER'S NAME First <i>James</i> Middle <i>Clendenin</i> Last <i>Shinnick</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Rowan</i> Last <i>Shinnick</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <i>Unknown</i> | | 17. INFORMANT <i>J. CLENDENIN SHINNICK</i> | | | Address <i>(SAME)</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Thrombosis (Convulsion)</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atrial Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Vascular Disease</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i> <i>Unknown</i> <i>Unknown</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>17 Oct</i> , 19 <i>67</i> , to <i>10 Nov</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10 Nov</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard R. Stephensen, MD</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <i>10 Nov 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Dr. Richard R. Stephensen</i> | | | | | | | | 22e. ADDRESS <i>Shangri-La Nursing Home</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>11/14/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i> ADDRESS <i>4905 York Rd. Balto. 12, Md.</i> | | | | | | 25a. REC'D BY REGISTRAR DATE <i>NOV 13 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Young</i> | | | |

MEDICAL CERTIFICATION



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| Item 6 Film 407 12/3/68 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15672 | | | | | | | | | | 15685 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Type or print) | | | | | | | | | | Month | | | | | | | | | | Day | | | | | | | | | | Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WILLARD | | | | | | | | | | M. | | | | | | | | | | SHIPLEY | | | | | | | | | | November | | | | | | | | | | 8 | | | | | | | | | | 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX | | | | | | | | | | 4 RACE | | | | | | | | | | 5 DATE OF BIRTH | | | | | | | | | | 6 AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | August 21, 1887 | | | | | | | | | | 81 1/2 | | | | | | | | | | YRS | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9 COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | U.S.A. | | | | | | | | | | | | | | | | | | | | Baltimore | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Catonsville | | | | | | | | | | 5226 Old Frederick Road | | | | | | | | | | Retired | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c CITY OR TOWN | | | | | | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Baltimore | | | | | | | | | | Catonsville | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 1506 Adamsview Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First | | | | | | | | | | Middle | | | | | | | | | | Last | | | | | | | | | | First | | | | | | | | | | Middle | | | | | | | | | | Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Unknown | | | | | | | | | | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | 16b SOCIAL SECURITY NO | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | 21228 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | (If yes give war or dates of service) | | | | | | | | | | 4109 | | | | | | | | | | Mrs. Margaret J. Shipley | | | | | | | | | | 1506 Adamsview Rd. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | IMMEDIATE CAUSE (a) <u>DEATH MYOCARDIAL INFARCTION</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1, 1967, to 11/8, 1968, that (I) (we) last saw the deceased alive on 11/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | Dr. John H. Shaw | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | 5800 Edmondson Ave., Balto., Md. 21228 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | 11-12-1968 | | | | | | | | | | Taylorsville Cemetery, Inc. | | | | | | | | | | Taylorsville, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Howard H. Hubbard | | | | | | | | | | 4107 Wilkens Ave. 21229 | | | | | | | | | | NOV 12 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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Item 13 Film 407 12/3/68
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

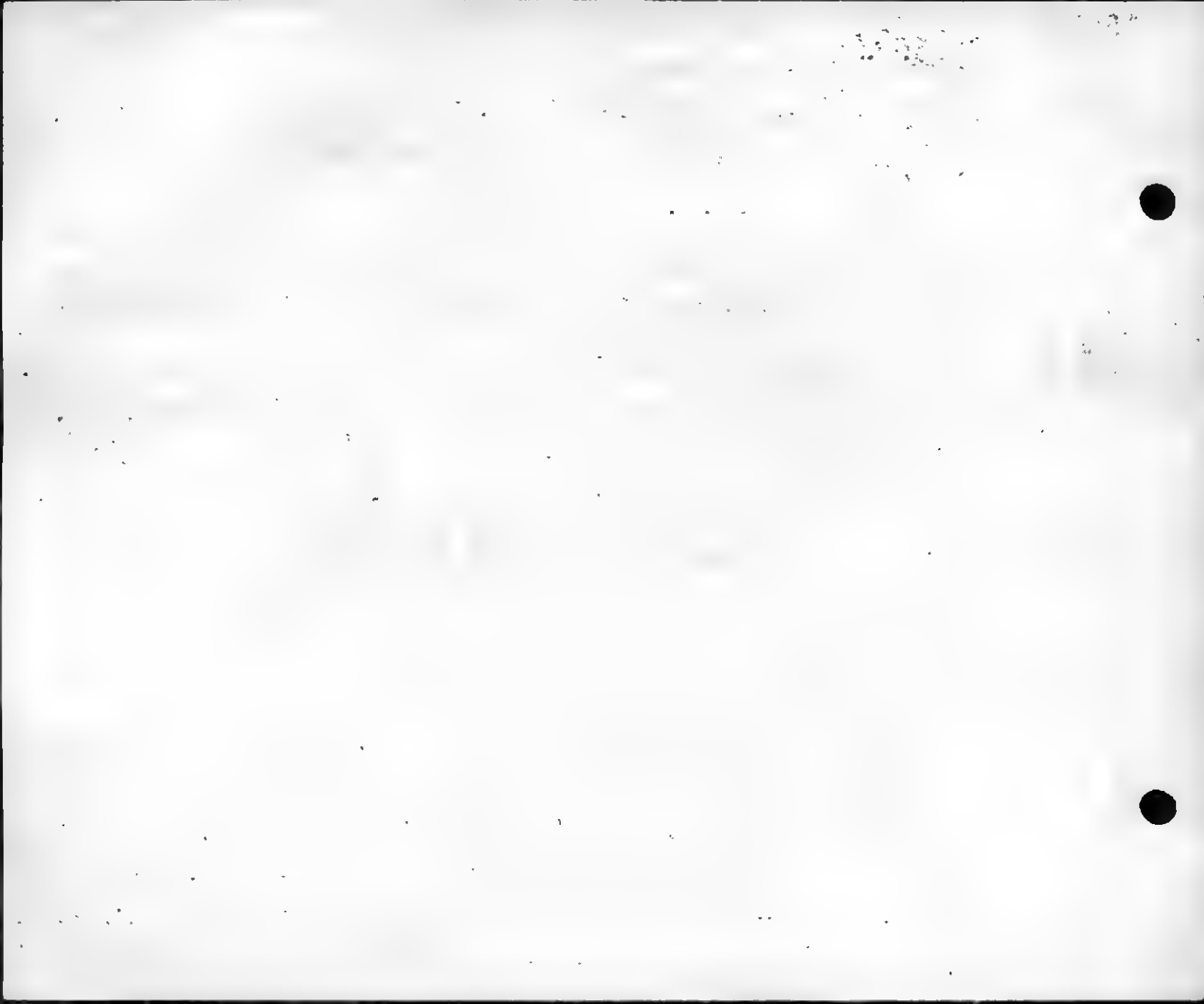
15676

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (Type or print) Sue Shoemaker | | | First Middle Last (Sue R. Shoemaker) | | | 2a. DATE OF DEATH Month Day Year November 25 1968 | | | 2b. HOUR 10:15 AM | | | | | |
| 3 SEX F | | | 4 RACE W | | | 5. DATE OF BIRTH 1-14-1888 | | | 6. AGE (In years last birthday) 80 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md | | |
| 10. CITY OR TOWN OF DEATH Reisterstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brent Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Reisterstown | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 300 Medora Rd. 12020 Reisterstown Road | | |
| 14. FATHER'S NAME First Middle Last Albert Cerneale | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No None | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Marian S. Sturniolo | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No None | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Marian S. Sturniolo | | | Address Charles Ct. E. 1212 Greendale Ave. Needham, Mass. | | | PERIOD BETWEEN ONSET AND DEATH 3 weeks | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis - generalized DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Needham, Mass. | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-28 , 1968, to 11-25 , 1968, that (I) (we) lost saw the deceased alive on 11-21 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE C. E. McWilliams M.D. | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 11-25-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS 1190 Reisterstown Rd. Reisterstown Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/27/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | 23d. LOCATION (City or Town) (County) (State) Ritchie Highway A.A. Co. Md | | | | | |
| 24. FUNERAL DIRECTOR Mr. Cully F.A. | | | ADDRESS 237 Patapsco Ave. | | | 25a. REC'D BY REGISTRAR NOV 26 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



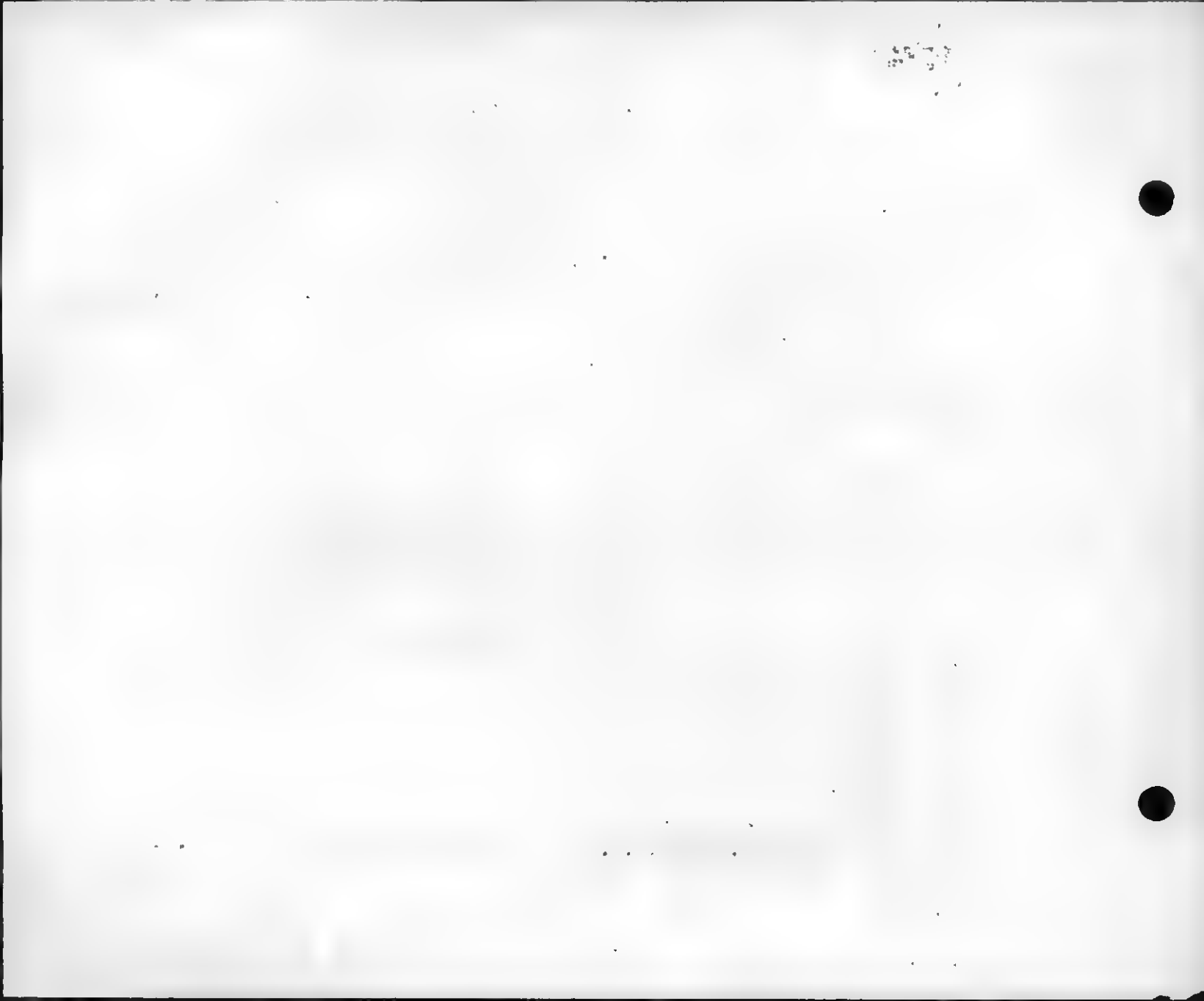
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 18&22a Film 407 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11-25-68ams 15672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|---|------------------------|---|---|---|---|---|---|--|
| 1 DECEASED NAME (Type or Print) David M. Shupe | | | 2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year Nov 2 1968 | | | 2b HOUR M | | |
| 3 SEX M | 4 RACE White | 5 DATE OF BIRTH Oct. 5, 1966 | 6 AGE (in years last birthday) 2 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | IF UNDER 24 HRS MONTHS DAYS HOURS MIN | 2c DATE PRONOUNCED DEAD Month Day Year Nov 2 1968 | | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore County, | | |
| 10 CITY OR TOWN OF DEATH Towson | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) STATE Maryland | | | 13b CITY OR TOWN Baltimore | | 13c INSIDE CITY 1/4 1/2 3/4 YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 1377 Limit Ave, # 21212 | |
| 14 FATHER'S NAME First Middle Last Harry Michael Shupe | | | 15 MOTHER'S MAIDEN NAME First Middle Last Diane L. Seimon | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17 INFORMANT ADDRESS family records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic pneumonitis probably caused by virus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 492x | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Nov. 3, 1968 | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE Nov. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State) Parkville, Balt., Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS C. F. EVANS & SON, INC 8802 Harford Rd | | | | 25a. REC'D BY REGISTRAR NOV 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15684

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) Anna Bankert | | | First Middle Last | | | 2a DATE OF DEATH 11 Month 18 oy 1968 | | | 2b. HOUR 11:30 | | |
| 3. SEX female | | | 4. RACE white | | | 5 DATE OF BIRTH Jan 26, 1877 | | | 6 AGE (In years last birthday) 91 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Germany | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing Home | | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) housewife | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c CITY OR TOWN Monkton | | | 13d INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME John Bankert | | | First Middle Last | | | 15 MOTHER'S MAIDEN NAME Philippino Tillman | | | First Middle Last | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT Dulaney Towson Nursing Home, 111 West Road | | | Address 21204 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar pneumonia -1409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION Street or RFD No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-10 , 19 62 , to 9-18 , 19 68 , that (I) (we) last saw the deceased alive on 9-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Henry L. McCorkle MD | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 11/19/68 | | |
| 22d PHYSICIAN'S NAME (Type) HENRY L. MCCORKLE MD | | | 22e. ADDRESS Phoenix, Maryland 21131 | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE 11-21-68 | | | 23c NAME OF CEMETERY OR CREMATORY Western Cemetery | | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc. | | | ADDRESS 1050 York Road | | | 25a REC'D BY REGISTRAR NOV 20 1968 | | | 25b REGISTRAR'S SIGNATURE William J. Judge | | |

8071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1 (4)
30M REV. 1-58

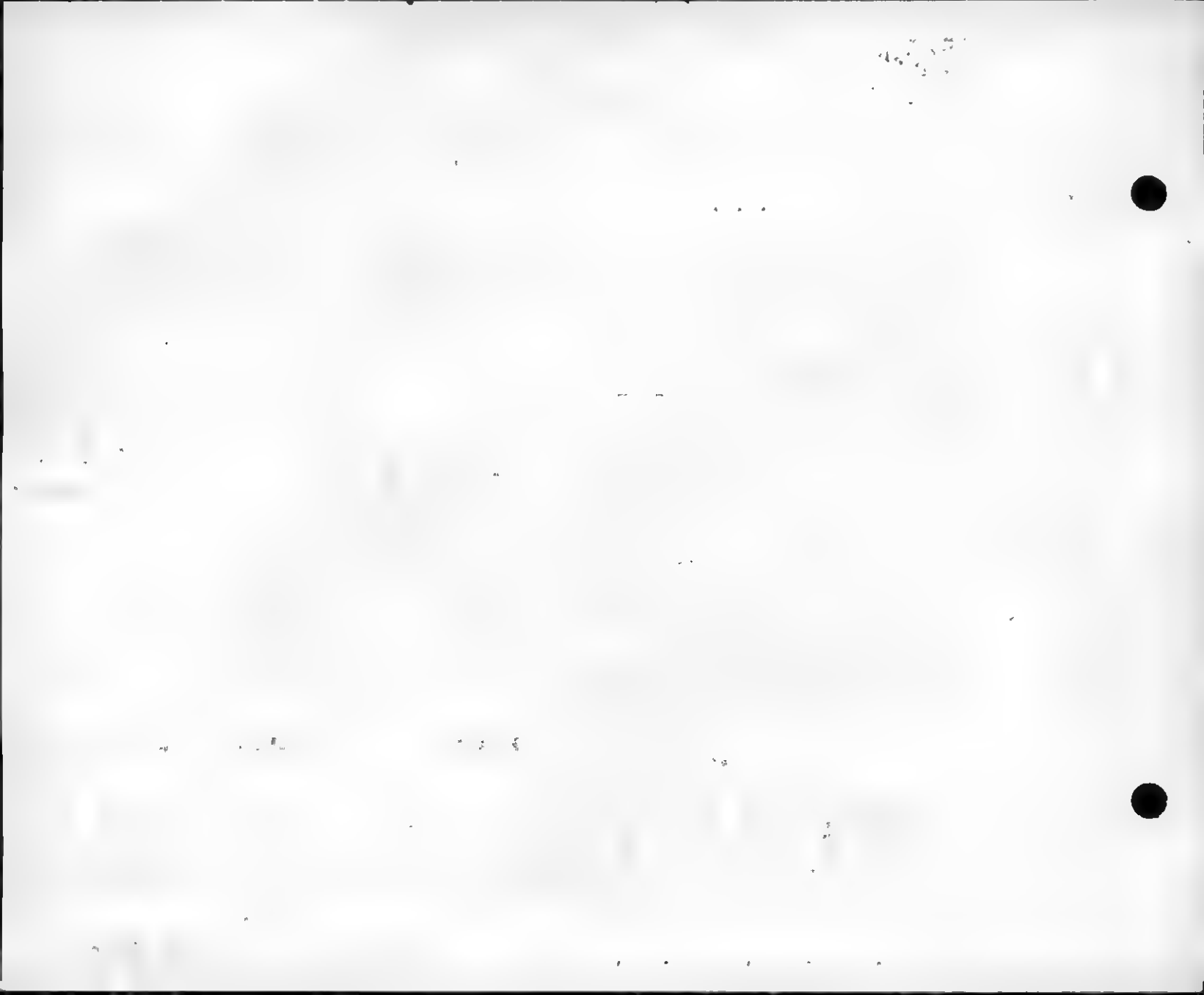
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15675

15675

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| 1 DECEASED-NAME (Type or print) ALPHONSE J. SILANSKAS | | | 2a DATE OF DEATH Month November Day 7 Year 1968 | | | 2b HOUR 2:25 P. M. | | | |
| 3 SEX male | | 4 RACE caucasian | | 5. DATE OF BIRTH Sept. 1, 1915 | | 6 AGE (In years last birthday) 53 YRS. | | 7 UNDER YEAR MONTHS 53 | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tailor | | 12b KIND OF BUSINESS OR INDUSTRY Self Employed | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 4600 Forest View Avenue | |
| 14. FATHER'S NAME First Middle Last Adolph Silanskas | | | 15. MOTHER'S MAIDEN NAME First Middle Last Magdalen ? | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes | | (If yes give year or dates of service) WW II | | 16b SOCIAL SECURITY NO 212-10-5600 | | 17. INFORMANT Mrs Helen M Silanskas | | Address Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. coronary arteriosclerosis (b) coronary DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 18 min. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 68 to 11/7 , 19 68 , that (I) (we) last saw the deceased alive on 11/7/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stuart D. Suday | | 22c. DATE SIGNED 11/8/68 | | 22d. PHYSICIAN'S NAME (Type) STU D. SUDAY | | 22e. ADDRESS 241 E. 35th St. (18) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY Garden Of Faith | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR NOV. 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

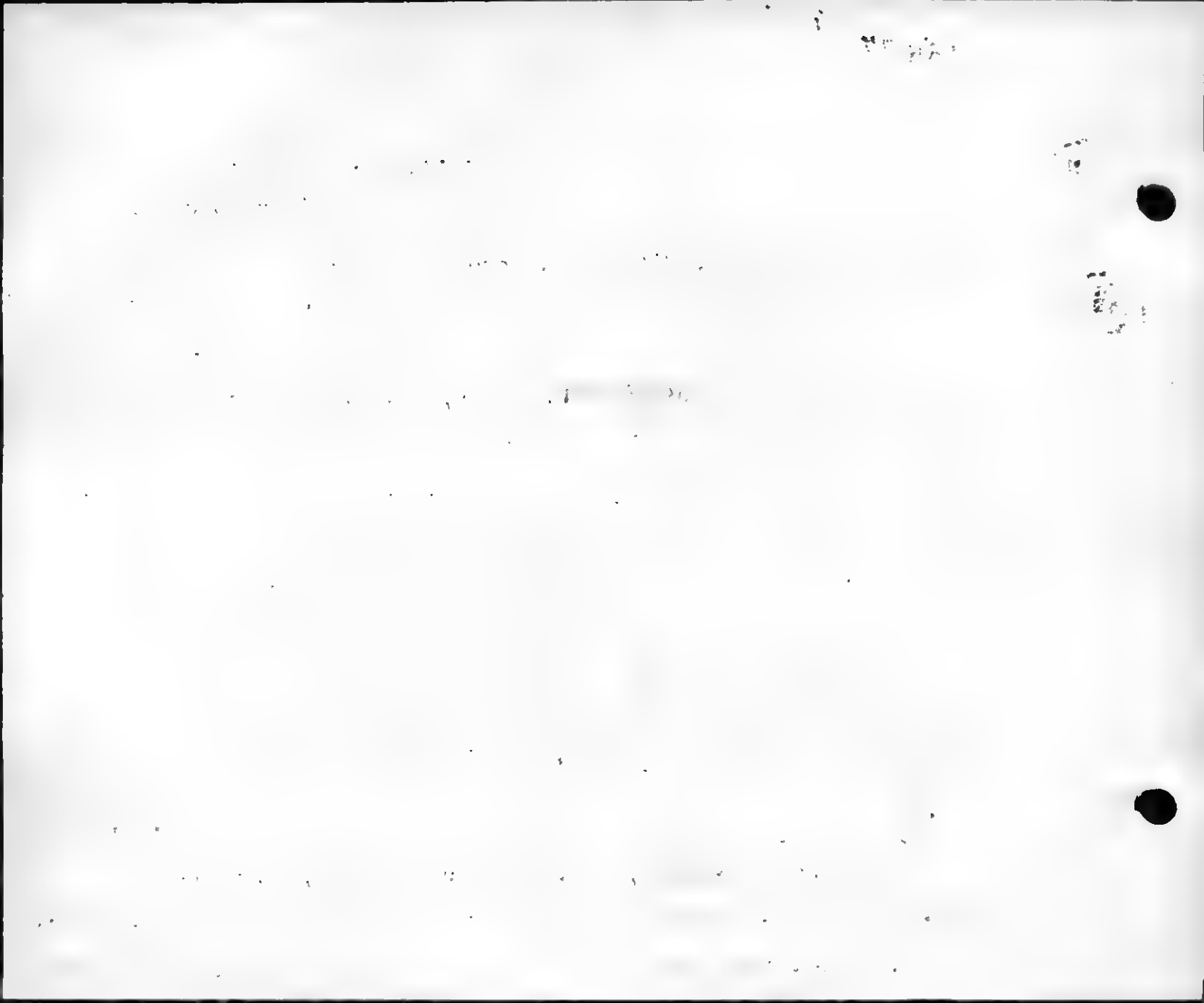


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

| 15676 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15690 | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| George Arthur Singleton | | | | Month Day Year Nov-20 1968 | | | | 8:30 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 4-14-13 | | | | 6. AGE (in years last birthday) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 4012 Bosley Ave | | | |
| 14. FATHER'S NAME First Middle Last George W. Singleton | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Singleton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO. 216-18-6696 | | 17. INFORMANT Records, Mt. Wilson State Hospital | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Emphysema 4 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ① Cor Pulmonale ② Fracture Rt. clavicle | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 12 yrs. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/23, 1968, to 11/20, 1968, that (I) (we) last saw the deceased alive on 11/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED Nov. 21, 1968 | | | |
| 22b. SIGNATURE W. Newcomer | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D. | | | | 22e. ADDRESS Mount Wilson, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Nov. 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY SOUTHERN | | 23d. LOCATION (City or Town) (County) (State) DUBLIN, HANFORD, MD. | | | | | |
| 24. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE NOV 26 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

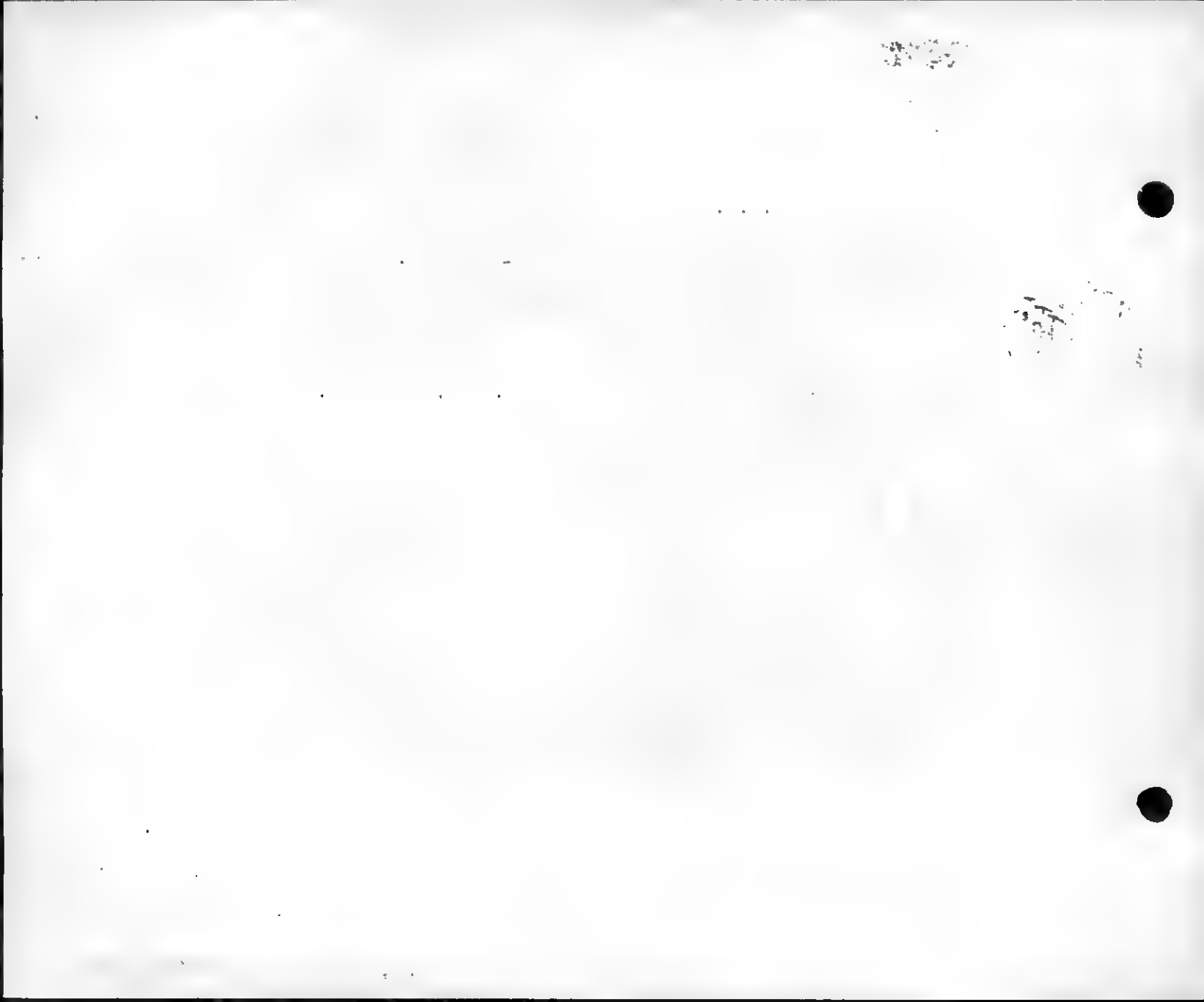
15677

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15691

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|---|--------|--|---------------------------|--|------|--|------------------|-------------------------|
| 1 DECEASED-NAME (Type or print) | | First | Middle | Last | 2a DATE OF DEATH Month | | Day | Year | 2b HOUR a. m. | |
| CLARENCE | | THOMAS | SMITH | NOVEMBER | | 24 | 1968 | 1:40 | | a. m. |
| 3. SEX MALE | | 4 RACE NEGRO | | 5. DATE OF BIRTH SEPTEMBER 5, 1926 | | 6 AGE (In years last birthday) 42 | | 7 UNDER 1 YEAR MONTHS | | 7 UNDER 24 HRS HOURS |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | Md | | |
| 10 CITY OR TOWN OF DEATH FORT HOWARD | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, or of retired) MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG. | | | | |
| 13a. USUA. RESIDENCE (Where deceased admits an) MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN CATONSVILLE | | 13d. STATE CITY, MD. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 15 GARNET AVENUE | | |
| 14 FATHER'S NAME First | | Middle | Last | 15 MOTHER'S MA DEN NAME First | | Middle | Last | | | |
| JAMES | | SMITH | MARY | BUTLER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES | | 16b. SOCIAL SECURITY NO. WW-11 | | 17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | BRAIN ABSCESS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | (b) | | RIGHT UPPER LOBE PNEUMONIA | | 6 WEEKS | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 3422 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 11 68, 19 to 11 24 68, 19, that (I) (we) saw the deceased alive on 11 24 68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Infan Aron Orer M.D. | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11 24 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D. | | 22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE 11/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL CEMETERY | | 23d. LOCATION (City or Town) BALTIMORE, MARYLAND | | (County) | | (State) |
| 24. FUNERAL DIRECTOR ELLIOTT FUNERAL HOME, 1129 N CAROLINE, BALTO, MD | | ADDRESS | | 25a. REC'D BY REG STRAR NOV 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



FOR STATE HEALTH DEPT.

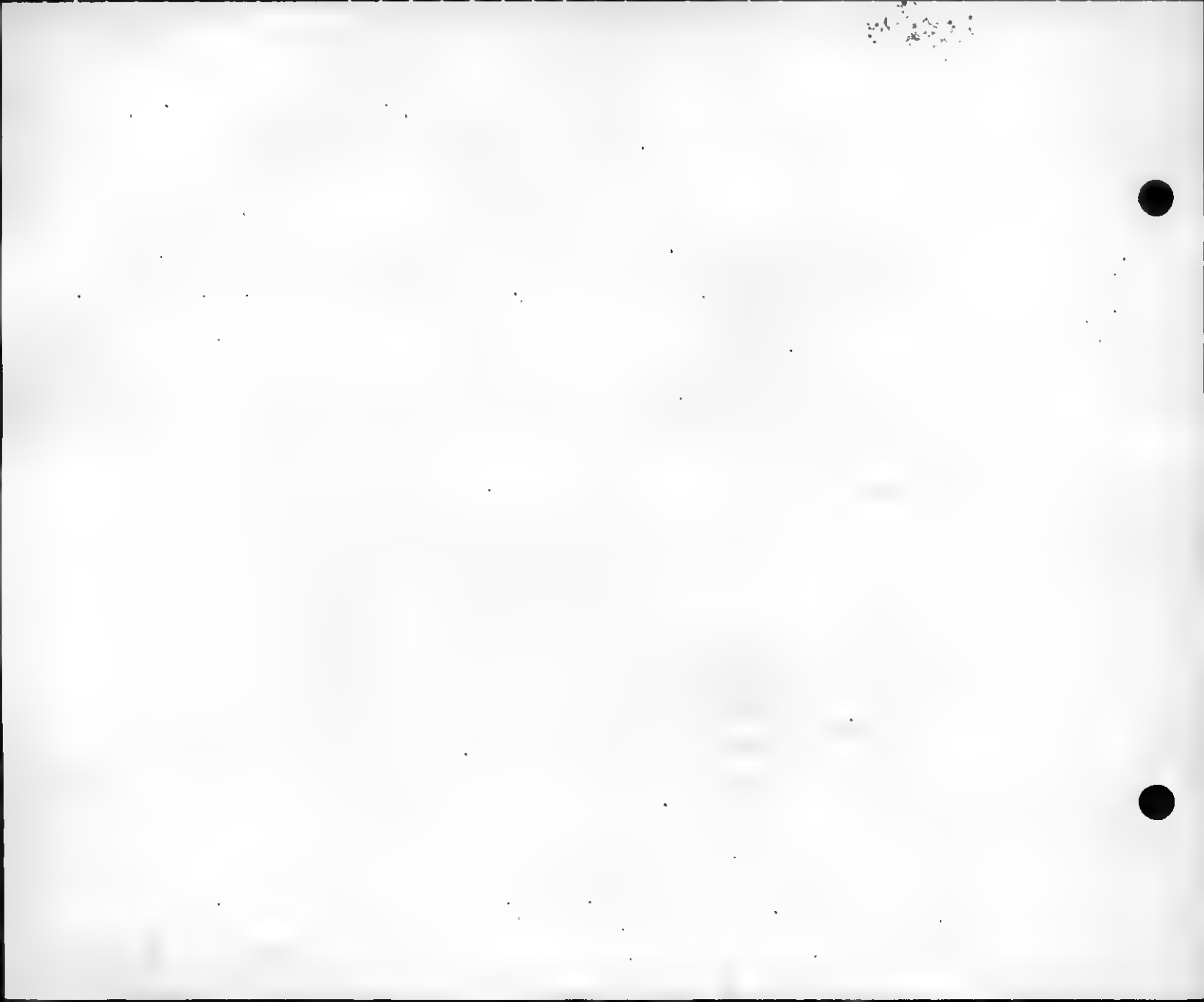
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

B-1

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|-----------|-----------------------------|---|---|----------------|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| JOHN GEORGE SMITH | | | | | | Month Day Year | | | 24 19 | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE in years (last birthday) | 7 UNDER 1 YEAR | 8 UNDER 24 HRS | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| MALE | CAUCASIAN | 9/28/1905 | 63 YRS | MONTHS DAYS HOURS MIN | MONTH DAY YEAR | 11 10 1968 | | | 24 19 | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | Md | | |
| md. | | U.S.A. | | | | BALTIMORE | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| DUNDALK 21222 | | | 3604 DUNMORE Rd | | | GENL. FOREMAN | | | STEEL MFG. | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| md. | | | BALTIMORE | | | DUNDALK | | | 3004 DUNMORE Rd | | |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| FREDERICK SCHMIDT | | | MARY R. APPEL | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS AS IN #13 | | |
| NO | | | 13-07-9778 | | | ANNA G. SMITH | | | A-B-C-D-E | | |
| 18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ACHD | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | ASSISTANT MEDICAL EXAMINER | | | 22b DATE SIGNED | | |
| THEO. C. PATERSON | | | | | | | | | 11/11/68 | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | | |
| THEO. C. PATERSON | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 11/10/1968 | | | OAK LAWN | | | BALTO. Co. Md | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| W. Burke Bradley, Dundalk, Md. 21222 | | | | | | NOV 12 1968 | | | J. Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 1514
304 REV. 7-68

15679

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15693

| | | | | | | | | |
|--|-----------|---|------------------|--|--------------------------------|--|---|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| CALVIN | | LEROY | SPROUL | Sr | 11 25 1968 | | 3:30aM | |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS M.N. | |
| Male | Caucasian | | 3/20/1906 | | 62 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Balto. Md. | | U.S.A. | | | | Baltimore Md | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | Greater Balto. Med.Center | | Clerk, Commercial Credit | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| 4306 Farley Ave | | 21206 | | Balto. | | | | 4306 Farley Ave. 21206 |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| Nelson | | | | Sproul | Sarah | | | Baynes |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | |
| No | | 218-18-2124 | | Florence H Sproul | | same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe coronary atherosclerosis</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) + x s | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/1, 1968, to 11/25, 1968, that (I) (we) lost the deceased alive on 11/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | |
| 22b. SIGNATURE Charles C Brown, M.D. | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/25/68 |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D. | | | | 22e. ADDRESS Greater Baltimore Medical Center | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 11-29-68 | | Grace Methodist Cem. | | Falls Rd. & Ridge Rd. Balto. Md | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| J. J. Reilly, Inc. Balto. Md. | | | | | | NOV 27 1968 | | J. Charles Jones |

2017

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the ~~death~~ certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|--|--|---|--|
| Item#23b 15630 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 10504 | |
| Film#G407 12/10/68 vmp | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME (Type or print) | | First Middle Last | | 2a. DATE OF DEATH | |
| MARVIN | | STANCIL | | Month Day Year 11 21 68 | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | |
| MALE | | NEGRO | | 7/18/28 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 6 AGE (n years last birthday) | |
| NORTH CAROLINA | | U.S.A. | | 40 YRS | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | F UNDER YEAR MONTHS DAYS | |
| | | BALTIMORE COUNTY, Md. | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| FORT HOWARD | | VET. ADL. HOSPITAL | | MASON TENDER | |
| 12b KIND OF BUSINESS OR INDUSTRY | | 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b CITY OR TOWN | |
| CONSTRUCTION | | MARYLAND | | BALTIMORE | |
| 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET AND NUMBER | | 13e STREET AND NUMBER | |
| | | 723 W. SARATOGA STREET | | | |
| 14 FATHER'S NAME First Middle Last | | 15. MOTHER'S M A-DEN NAME First Middle Last | | | |
| MARVIN STANCIL | | ROSA COBB | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | |
| YES | | WW PL 28 | | CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) CARCINOMATOSIS (ORIGIN UNKNOWN) | | 7 MONTHS | | | |
| 1771 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 14 | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20c. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| | | P.M. 19 | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC) | | 21f LOCATION Street or R.F.D. No City or Town County State | |
| | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 5/1/68, 19, to 11/21/68, 19, that (b) (we) last saw the deceased alive on 11/21/68, 19, and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (do not) view the body after death | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| Nan Ann Orer M.D. | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 11/21/68 | |
| 22d PHYSICIAN'S NAME (Type) | | 22e ADDRESS | | | |
| INFAN A. ORER, M. D. | | VAH FORT HOWARD, MARYLAND | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 11/26/68 | | BALTIMORE NATIONAL | |
| 23d LOCATION (City or Town) (County) (State) | | 23e REC'D BY REGISTRAR | | 23f REGISTRAR'S SIGNATURE | |
| BALTIMORE, MARYLAND | | NOV 27 1968 | | Charles Judge | |
| 24. FUNERAL DIRECTOR | | | | | |
| COOPER FUNERAL HOME 2222 W. NORTH AV. BALTIMORE, MD. | | | | | |



15681

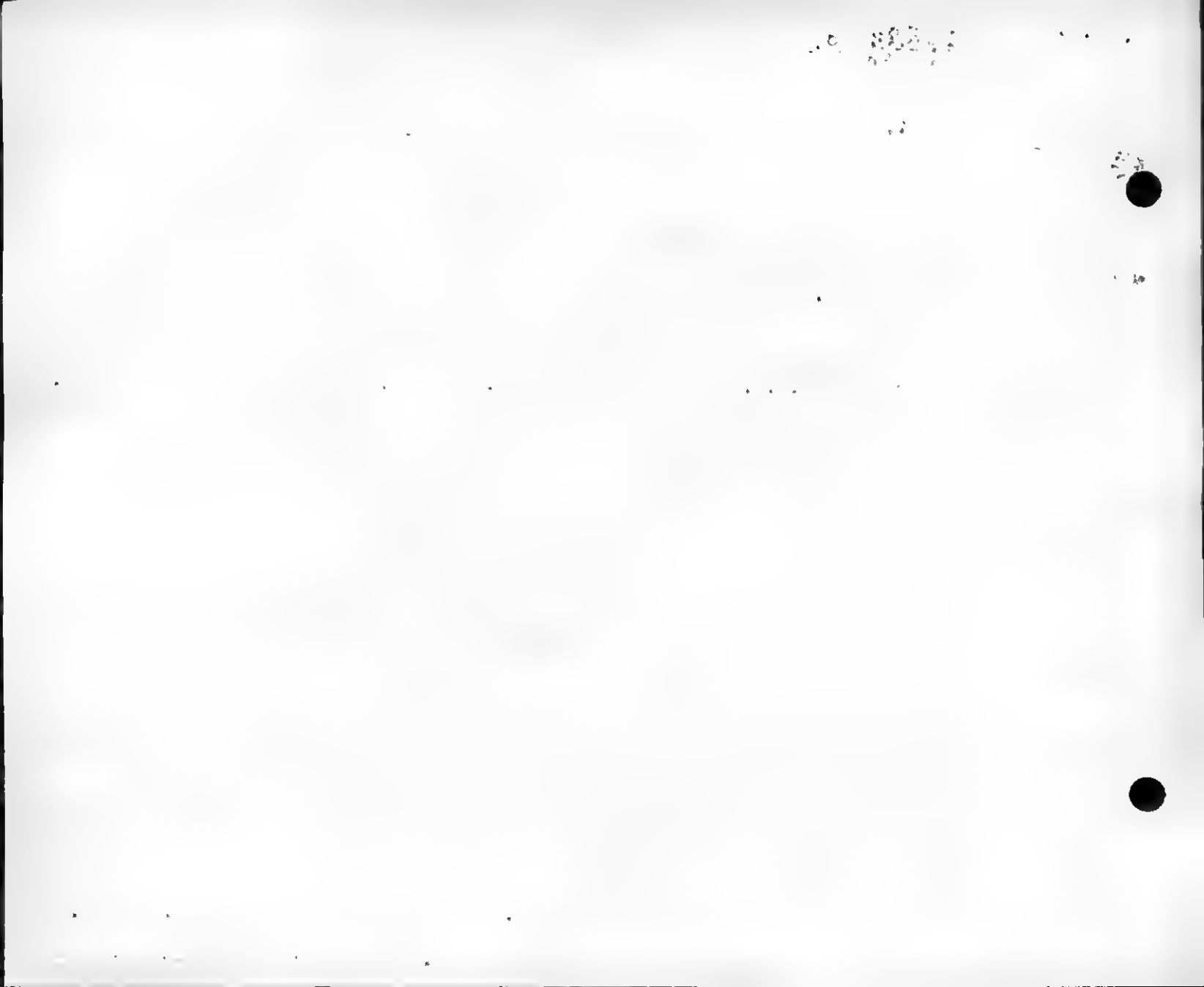
15681

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--------------------------------------|--|---|
| 1. DECEASED NAME (Type or print) Starnes, Charles | | | 2a. DATE OF DEATH Month NOV Day 5 Year 1968 | | | 2b. HOUR 129 M | |
| 3. SEX male | | 4. RACE White | | 5. DATE OF BIRTH 5-5-95 | | 6. AGE (In years last birthday) 73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Minister, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. CO. GEN. HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Rockdale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last Charles Starnes | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mollie Geiman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes give war or dates of service) W.W.I. | |
| 16b. SOCIAL SECURITY NO. 213 03 2381 | | | 17. INFORMANT Address Mrs. Anita E. Starnes, 3508 Hillsmere Rd. 21207 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT UPPER LOBE PNEUMONIA | | | | | | | |
| 5310 DUE TO, OR AS A CONSEQUENCE OF (b) GASTRIC ULCERATIONS WITH BLEEDING | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SUBCAPITAL FRACTURE RIGHT FEMUR | | | | | | | |
| 19a. DATE OF OPERATION 10-14-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UPPER G-I BLEEDING | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home farm street factory) OFFICE BUILDING ETC | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-27 , 19 68 , to 11-5 , 19 68 , that (I) (we) last saw the deceased alive on 11-5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. G. Santoro | | 22c. PHYSICIAN'S NAME (Type) G. Santoro | | 22d. ADDRESS MDA | | 22e. DATE SIGNED 11-5-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 11 8 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co; Md. | |
| 24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd; Randallstown, Md | | 25a. REC'D BY REGISTRAR NOV 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15682 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15896 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|---|------------------------------------|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) CORA E. STEARNS | | | | | | 2a. DATE OF DEATH Month 11 Day 6 Year 68 | | 2b. HOUR 7:35 M | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Nov. 6, 1888 | | 6. AGE (In years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 1 YEAR HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE, | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MED. CEN. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5700 The Alameda | | |
| 14. FATHER'S NAME First Middle Last Alfred Turner | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Juniata Waters | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO 220-44-3378 | | 17. INFORMANT Mrs. Edward Paxton | | | | Address Palos, Illinois | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4369 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 351X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State 11/2 68 11/6 68 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/6 , 19 68 , to 11/6 , 19 68 , that (I) (we) last saw the deceased alive on 11/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE B.R. Friedlander MD | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) B.R. FRIEDLANDER MD | | | | | | 22e. ADDRESS Gbmc Balto. Co., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-8-68 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION (City or Town) (County) (State) Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

8003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

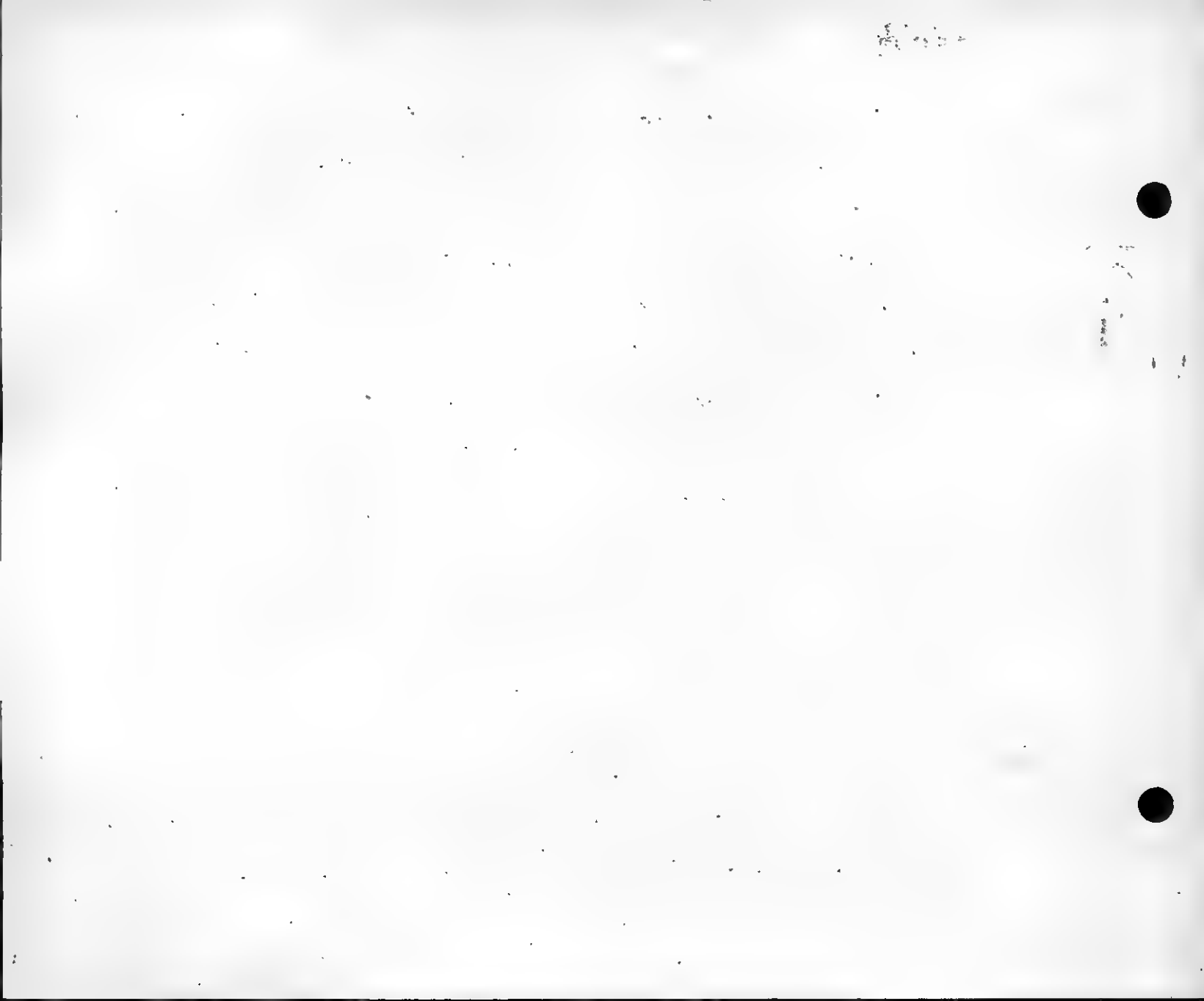
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15682

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15691

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) ANNA KATHERINE STELTZ | | | 2a. DATE OF DEATH Month 11 - Day 12 - Year 68 | | | 2b. HOUR 2:30 P M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 2-4-1886 | | 6. AGE (In years last birthday) 82 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) STELLA MARIS Hospice | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 17 Mills Road | | 14. FATHER'S NAME First Middle Last FRANCIS H. FOGLE | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY ELLEN O'KEEFE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO | | 16b. SOCIAL SECURITY NO 218-54-2332 | | 17. INFORMANT S. M. Hospice Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema - 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HASCUO DUE TO, OR AS A CONSEQUENCE OF (c) CVA - | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 4 hrs - |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-19 , 19 67 , to 11-12 , 19 68 , that (I) (we) last saw the deceased alive on 11-12-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. Lee Robbins mo. | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-12-68 | |
| 22d. PHYSICIAN'S NAME (Type) E. Lee Robbins Robbins | | | | 22e. ADDRESS 812 Mockingbird Lane 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE Nov 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph | | 23d. LOCATION (City or Town) (County) (State) Texas BALTO MD. | |
| 24. FUNERAL DIRECTOR Wm Cook Brooks Towson, 1050 York Rd Towson Md 21204 | | | | 25a. REC'D BY REGISTRAR DATE NOV 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) Served As: VIRGIE OFFENOFF | | First Middle Last | | 2a. DATE OF DEATH Month Day Year NOVEMBER 30 1968 | | 4. HOUR a. m. | |
| 3. SEX Male | | 4. RACE Colored | | 5. DATE OF BIRTH 11/5/99 | | 6. AGE (In years last birthday) 69 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore, Md | |
| 10. CITY OR TOWN OF DEATH Fort Howard | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cook | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 1527 Edmondson Avenue | | 14. FATHER'S NAME First Middle Last TOBIAS STEWART | | 15. MOTHER'S MAIDEN NAME First Middle Last HANNAH ALLEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16b. SOCIAL SECURITY NO. 216-01-0330 | | 17. INFORMANT Clin. Rec. VAIL, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) UREMIA | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 443X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Sept. 17, 1968 , to Nov. 30, 1968 , that (1) (we) last saw the deceased alive on Nov. 30, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Infan A. Orer, M.D. | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11/30/68 | |
| 22d. PHYSICIAN'S NAME (Type) INFAN A. ORER, M.D. | | | | 22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Arlington Phillips Funeral Home Balto. Md. | | | | ADDRESS 1727 N. Monroe St. | | REC'D BY REGISTRAR DEC 6 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | |

VR A 31
45M 1169

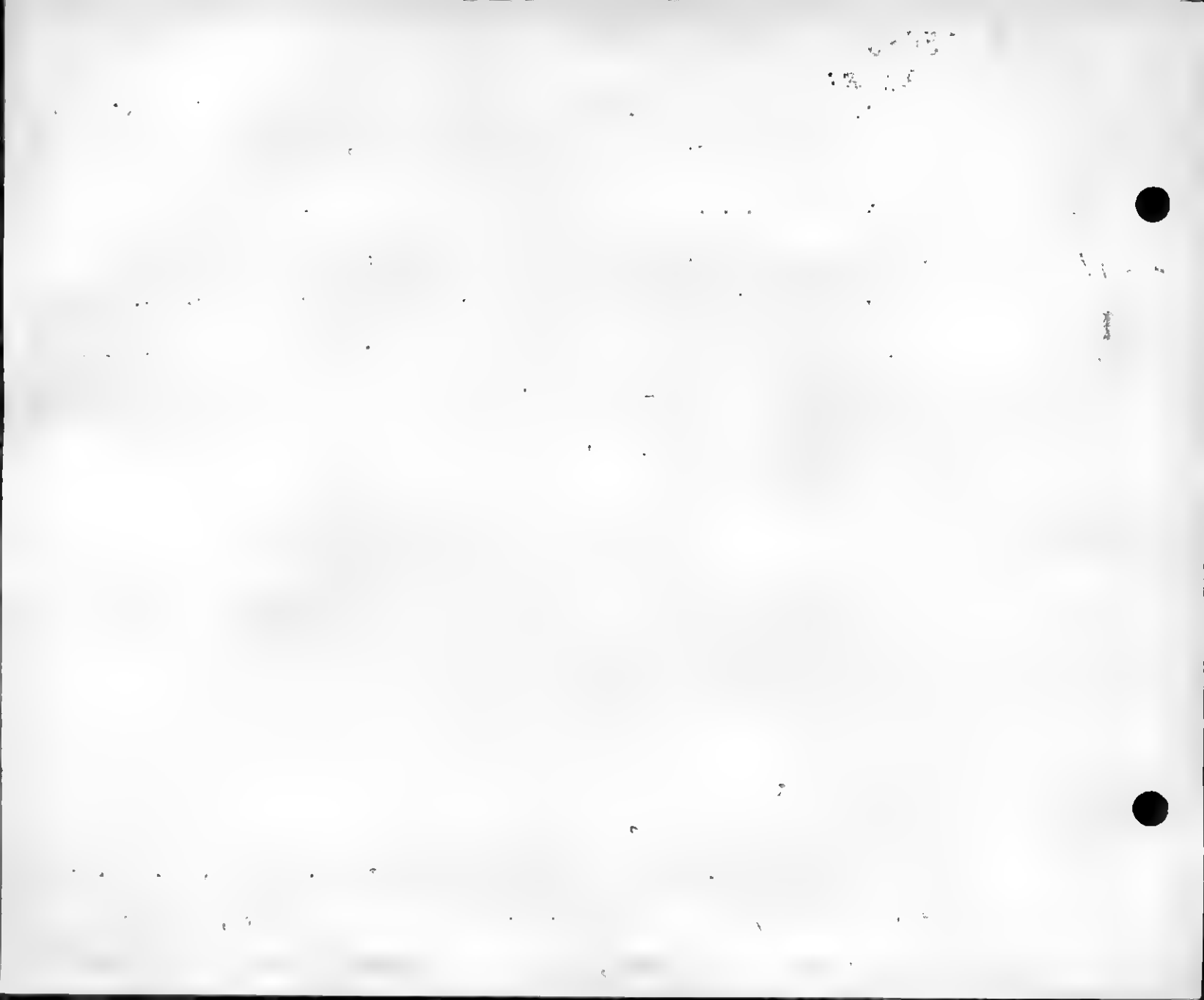
1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First JOSEPH | | Middle XX S | | Last TADDUNI | | 2a. DATE OF DEATH Month 11 Day 12 Year 1968 | | |
| 3. SEX Male | | 4 RACE White | | 5 DATE OF BIRTH September 11, 1912 | | | 6 AGE (In years last birthday) 56 YRS | | 2b. HOUR 7:30 P.M. | | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Restaurantour | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 7103 Harford Rd. | | |
| 14. FATHER'S NAME First Middle Last Salvatore Tadduni | | | 15. MOTHER'S MAIDEN NAME First Middle Last Maria Nuciforo | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 217-16-6592 | | 17. INFORMANT Mrs Angelina Tadduni | | | Address Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 431.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>68</u> , to <u>11/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> 19 <u>68</u> , and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Gualberto C. Gokim M.D.</u> DEGREE | | | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 11-12-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Gualberto C. Gokim | | | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | | 23d. LOCATION (City or Town) Baltimore, Maryland | | (County) (State) | | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15686
CERTIFICATE OF DEATH

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Balto. Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 941 Coleridge Rd. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 941 Coleridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Reginald V. Tarlton | | | 4. DATE OF DEATH Month Nov. Day 13 Year 19 68 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 22, 1906 | 9. AGE (in years last birthday) 62 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY Pinkerton Co. | | 11. BIRTHPLACE (County & State, or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Murray T. Tarlton | | | 14. MOTHER'S MAIDEN NAME Marie A. Mortica | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-03-8223 | | 17. INFORMANT Mrs. Bessie M. Tarlton Address Balto. Md. 21229 941 Coleridge Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of duodenum 1520 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fastidiousness dis. benign prostatic hypertrophy | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 19 59 to Nov. 13 68 that (I) (we) last saw the deceased alive on Nov. 12 19 68 and that death occurred at 8:20 M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Christian S. McGoss | | | | 22b. DATE SIGNED 11/14/68 | |
| 22c. PHYSICIAN'S NAME (Type) Christian S. McGoss, M.D. | | | | 22d. ADDRESS 315 St. John's Lane, Ellicott City, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov. 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | |
| 23d. LOCATION (City, town or county) (State) Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR Balto. Md. 21229 G. Truman Schwab 5151 Balto. National Pike | | | | 25a. REC'D BY REGISTRAR NOV 18 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15687 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15701 | | | | | |
|--|--|--|---------|--|--|------------------|--|--|--|---|--------------------------------|--|--|--|--|-----------------------------|--|--|--|---|---------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | |
| JULIUS HENRY THIELE | | | | | | | | | | 11 Month 30 Day 1968 | | | | | M | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | | | 6 AGE (In years lost birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS HOURS MIN | | | | |
| M | | | W | | | 11-8-1899 | | | | | 69 YRS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | |
| MARYLAND | | | | | USA | | | | | | | | | | BALTIMORE | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| CATONSVILLE | | | | | FOREST HAVEN CONV. | | | | | MACHINIST | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Res. date before admission), STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | |
| MD | | | | | | | | | | BALTO. | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 5150 EDMONDSON AVE | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | |
| JULIUS HENRY THIELE | | | | | EMMA MEYER | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17 INFORMANT | | | | | Address | | | | | | | | | | |
| YES WW II | | | | | 214-40-4643 | | | | | J. HENRI SIEGEL | | | | | 5150 EDMONDSON AVE | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BREAST CANCER</u> | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>NEPHROSIS</u> | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/10, 1968, to 11/30, 1968, that (I) (we) last saw the deceased alive on 11/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John H. Shaw MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED 12/3/68 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>John H. Shaw MD</u> | | | | | | | | | | | | | | | 22e. ADDRESS <u>5801 EDMONDSON AVE BALTO MD</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | |
| BURIAL | | | | | 12-4-68 | | | | | BALTIMORE NATIONAL CEM. BALTO. | | | | | MARYLAND | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Edward J. Weber</u> <u>5311 EDMONDSON AVE</u> | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>DEC 3 1968</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |

1941

1941

FOR STATE
HEALTH DEPT.

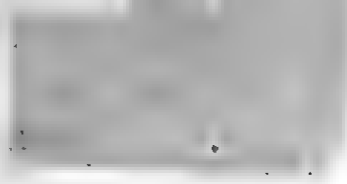
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed, within 24 hours after death, by any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1570

| | | | | | | | | | |
|--|------------------------|---|---|---|---|--|---|--|--|
| 1 DECEASED NAME (Type or Print) GEORGE W. THOMPSON | | | 2a. DATE KNOWN OF DEATH Month Nov. Day 8, Year 1968 | | | 2b. HOUR 9:30 PM | | | |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH 12/8/1906 | 6 AGE (in years last birthday) 61 YRS | 7 UNDER 1 YEAR MONTHS DAYS | 7 UNDER 24 HRS HOURS MIN. | 2c. DATE PRONOUNCED DEAD Month Nov. Day 8, Year 1968 | | | 2d. HOUR 9:30 PM |
| 7a. BIRTHPLACE (State or foreign country) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Proprietor | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6580 Loch Raven Blvd. |
| 14. FATHER'S NAME First George Middle W. Last Thompson | | | 15. MOTHER'S MAIDEN NAME First Catherine Middle Mannion | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 212-30-4083 | | 17 INFORMANT Mrs. Margaret M. Hart ADDRESS (Same) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: Multiple stab wounds of chest IMMEDIATE CAUSE (a) Multiple stab wounds of chest DUE TO, OR AS A CONSEQUENCE OF (b) 766x DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7. x x | | | | | | | | | |
| 19a. DATE OF OPERATION 7. x x | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Nov. ?/ 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Stab wounds of chest | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No 6580 Loch Raven Blvd | | City or Town Balto. Md. | | State Md. |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED November 9, 1968 | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION (City or Town) Baltimore | | (County) Md. |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | ADDRESS 4905 York Rd. Balto. Md. | | | 25a. REC'D BY REGISTRAR NOV 14 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



40021
100

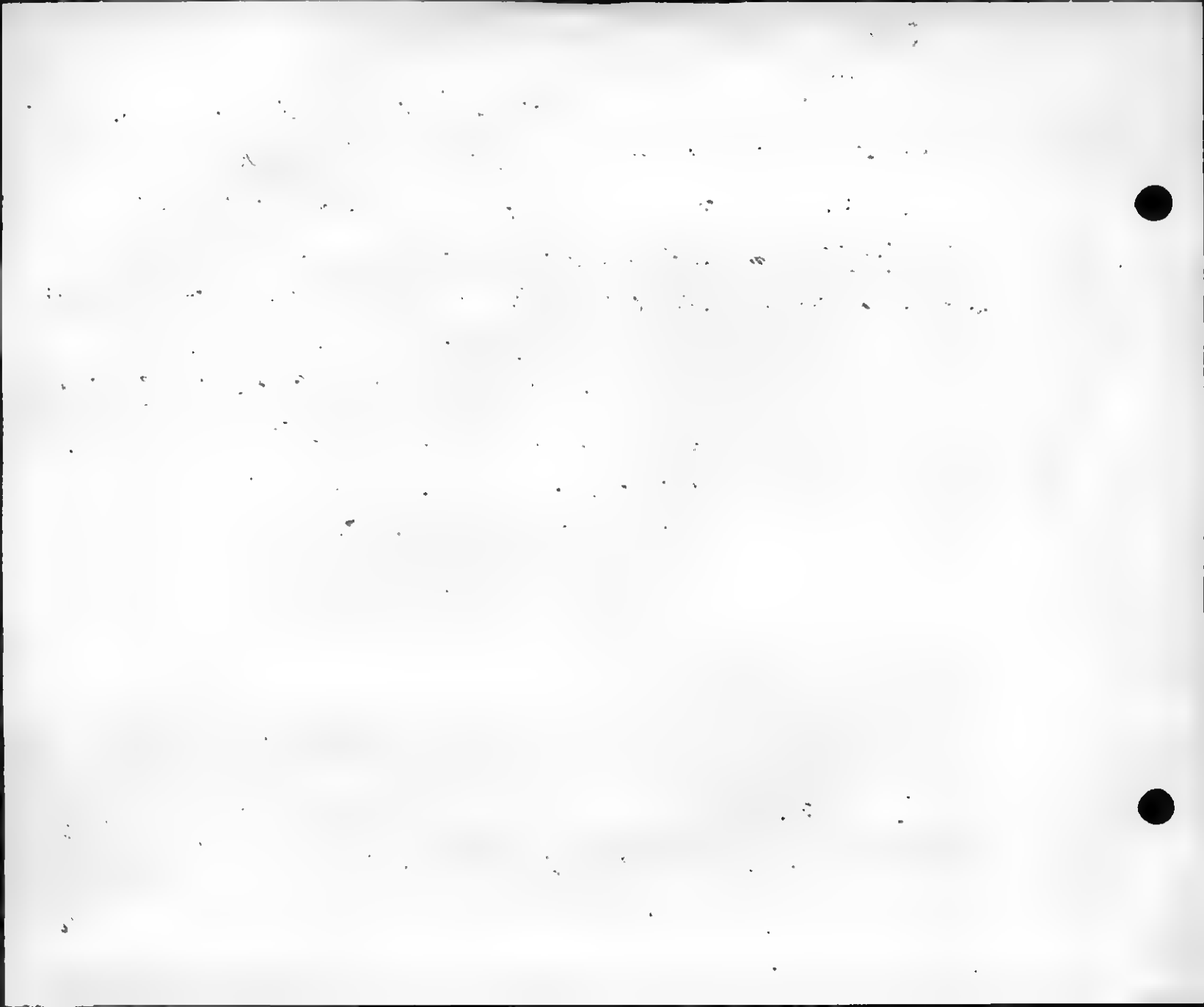


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| <div>15683</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15703</div> <div>Item #7b, Film 426 11/20/68 km</div> <div>CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) STANLEY First TOM Middle AVICH Last | | | | 2a. DATE OF DEATH Month NOV Day 10 Year 1968 | | | | 2b. HOUR 12 M | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH 8-15-87 | | 6 AGE (In years lost birthday) 81 YRS | | 7 UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7 IF UNDER 24 HRS HOURS 0 M.N. 0 | |
| 7a. BIRTHPLACE (State or foreign country) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? 1001 Poland | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE, MD | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RAILROAD WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE PENNS COUNTY BALTO | | | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 437 S. PADDIN' ST. | | | |
| 14 FATHER'S NAME First JULIAN Middle J Last | | | | 15 MOTHER'S MAIDEN NAME First VICTORIA Middle BARTKEWIES Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> | | | | 16b. SOCIAL SECURITY NO. 2W-03-9444 A 304972 | | 17. INFORMANT MRS ANN STANLEY WILL Address 4861 ST. ST. 34 CHARD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (b) PULMONARY EMPHYSEMA AND (c) CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RAAPT-2 TEMPLE HILLS #31 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLECTIC HEART DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-22-68 to 11/10/68 , that (I) (we) last saw the deceased alive on 11/10/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE D. MARIN DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 11/10/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RAFAEL. MARIN | | | | | | 22e. ADDRESS SPRING GROVE STATE HOSP | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 11-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD. | | | | | |
| 24 FUNERAL DIRECTOR WALTERS FUN'L HOME PRATT & STRICKER SR. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR NOV 13 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



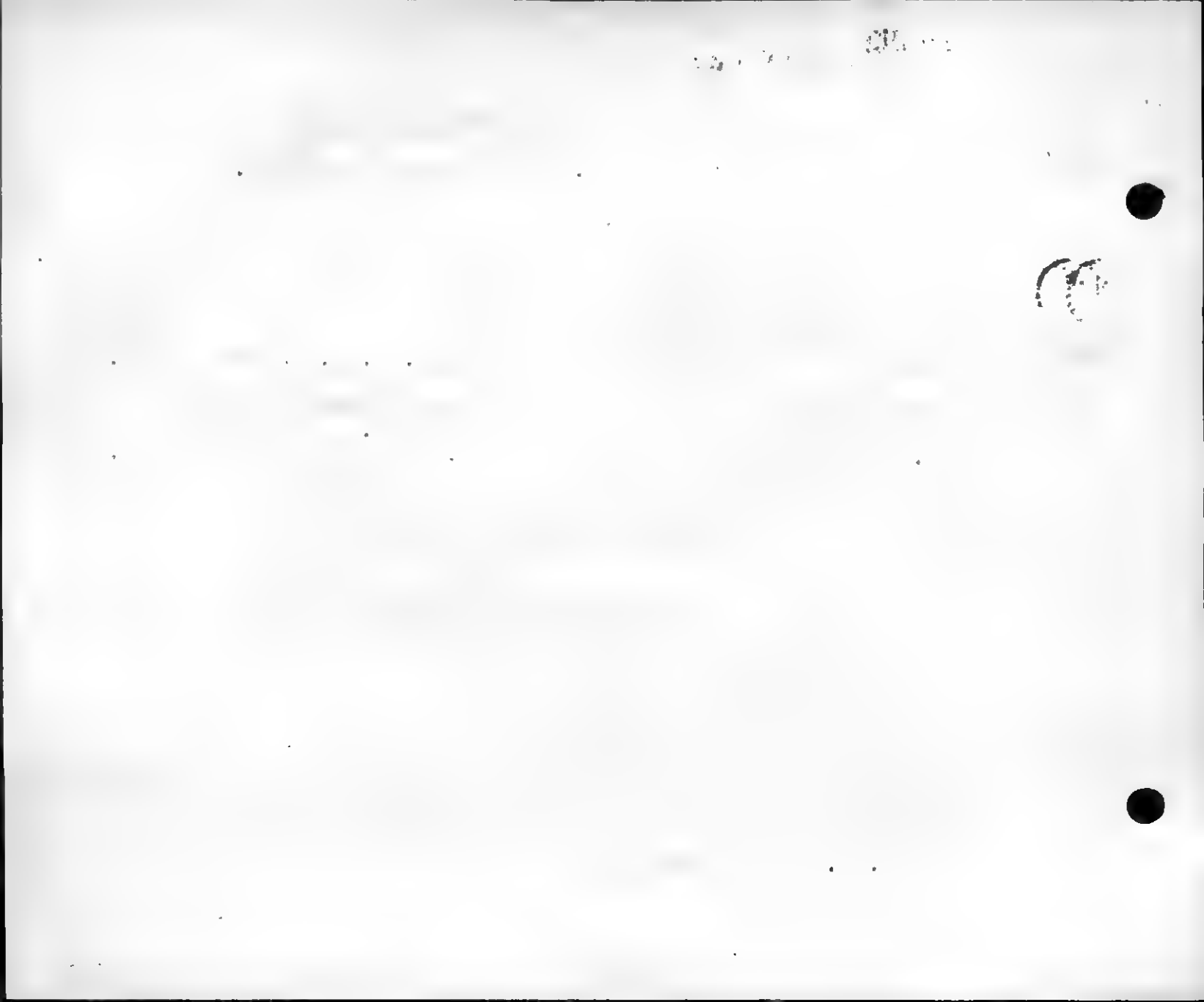
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15690

15704

| | | | | | | | |
|--|----------------------------------|--|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Baltimore</u> | | | | c. LENGTH OF STAY IN 1b <u>13 yrs.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at Home, 8545 Pulaski Hiway.</u> | | | | d. STREET ADDRESS <u>8545 Pulaski Highway</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>FANNIE Smyth TREGGETT</u> | | | | 4. DATE OF DEATH Month <u>NOV.</u> Day <u>20</u> Year <u>1968</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/20/71</u> | 9. AGE (in years last birthday) <u>97</u> yrs. | IF FUNER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Quebec, P. Q. Canada</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | | | 13. FATHER'S NAME <u>Robert Smyth</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Fannie SMYTH Quirk</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT <u>son, 8545 Pulaski Hiway</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 4129 DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1965</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | |
| 20f. (City or town) (County) (State) <u> </u> | | | | 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1967</u> to <u>Nov 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov 18, 1968</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>G. M. Baumgardner</u> | | | | 22b. DATE SIGNED <u>11/20/68</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u> | | | | 22d. ADDRESS <u>Balto 21237</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | | 23b. DATE THEREOF <u>11-20-68</u> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u> </u> | | | | 23d. LOCATION (City, town or county) (State) <u>Plattsburg, New York</u> | | | |
| 24. FUNERAL DIRECTOR <u>Joseph A. 7401 Belair Rd.</u> | | | | 25a. REC'D BY REGISTRAR <u> </u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u> </u> | | | | DATE <u>NOV 22 1968</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (1)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|-------------------|--|--|--|--|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 15692 | | 15705 | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JAMES LEROY TRONE | | | | | | Month Day Year | | 11 26 68 7:20P M | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| male | | white | | 11-4-1899/1900 | | 69 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Pennsylvania | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | St. Joseph Hospital | | DENTIST | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Cecil Co. | | Elkton | | | | 103 Park Circle | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Samuel D. Trone | | | | Susan Rinehart | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | 214-344606 | | Alice D. W. Trone 103 Park Circle, Elkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of colon with liver | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF metastases | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-23, 1968, to 11-26, 1968, that (I) (we) last saw the deceased alive on 11-26-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Antonio G. DeLeon M.D. | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 11-26-68 | |
| 22d. PHYSICIAN'S NAME (Type) Antonio G. DeLeon, M.D. | | | | 22e. ADDRESS 7620 York Road, Baltimore, Md. 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11-29-68 | | Gilpin Manor Mem. Pk. | | Elkton Cecil, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| PIPPIN FUNERAL HOME, Elkton, Md. | | | | DATE DEC 2 1968 | | Charles Judge | | | |

3000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-41
30M REV 6/68

15692

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15766
CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last L. Elmer Troyer | | | 2a. DATE OF DEATH Nov. Month 25 Day 68 Year | | 2b. HOUR 3:45 P.M. |
| 3 SEX M | 4. RACE Cauc. | 5. DATE OF BIRTH May 19, 1895 | | 6. AGE (In years last birthday) 73 YRS. | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Balto. | | |
| 10. CITY OR TOWN OF DEATH Monkton | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Troyer Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY Farm- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Balto. | 13c. CITY OR TOWN Monkton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER Troyer Rd. | |
| 14. FATHER'S NAME First Middle Last Lewis Troyer | | 15. MOTHER'S MAIDEN NAME First Middle Last Jennie Melvin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No. | | 16b. SOCIAL SECURITY NO 214-20-1138 | | 17. INFORMANT Address L. Elwood Troyer, White Hall, Md. 21161 | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A.S.C.V. disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>april 68</u> , 19 <u>68</u> , to <u>11/25</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11/24</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A. M. FRAKE M.D. | | | | 22c. DATE SIGNED 11/26/68 | |
| 22d. PHYSICIAN'S NAME (Type) A. M. FRAKE | | 22e. ADDRESS PARKING MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11/27/68 | 23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem. | 23d. LOCATION (City or Town) (County) (State) Monkton, Balto. Md. | | |
| 24. FUNERAL DIRECTOR James Hartenstein, New Freedom, Pa. | | 25a. REC'D BY REGISTRAR DANOV 29 1968 | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

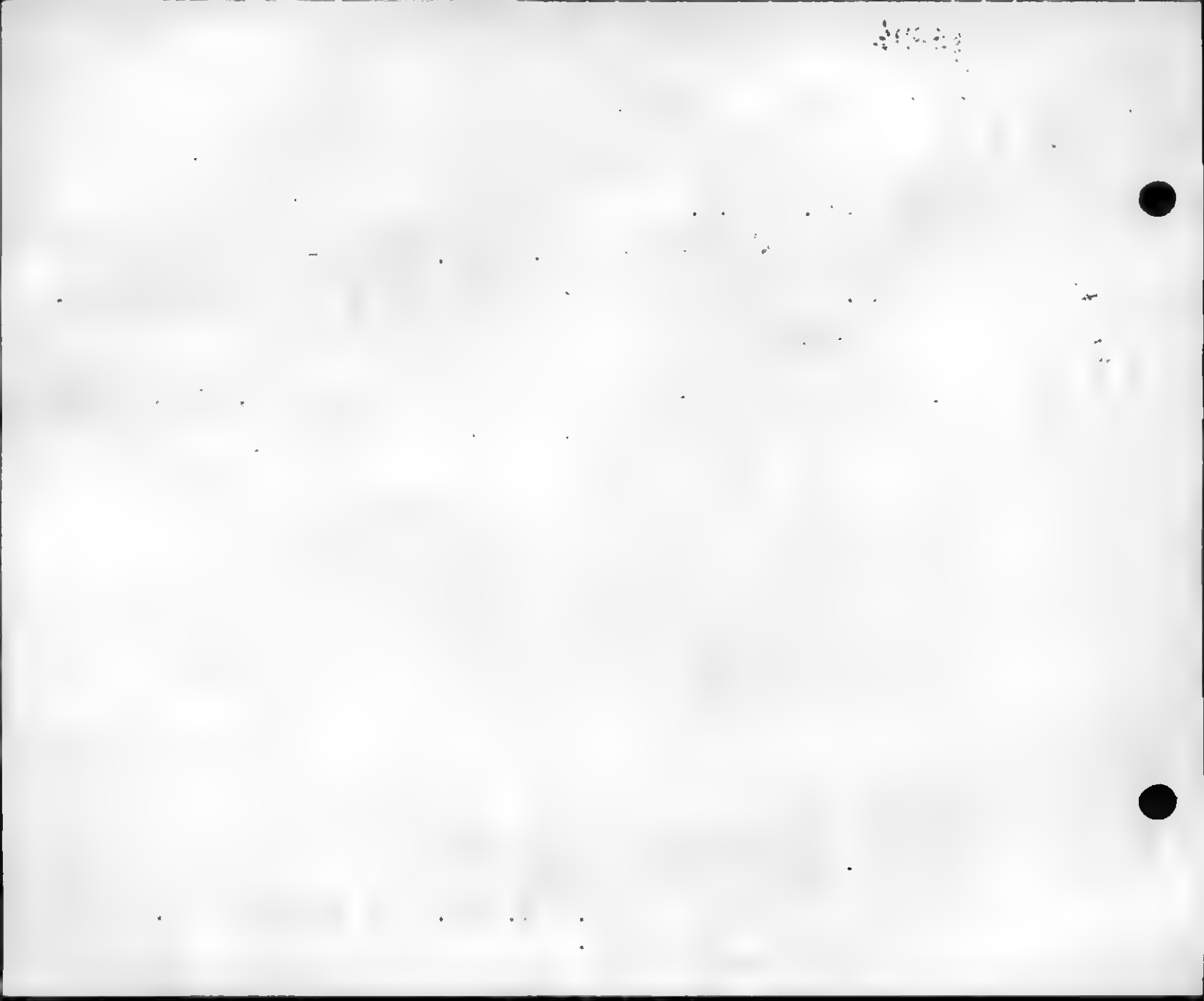
89971

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--------|---|-------------------|--|--------------------------------|--|------------------------------|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b HOJR |
| JOHN | | GEORGE | | TUEK | | | | 11-18 1968 | | 28 M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD Month Day Year | |
| male | white | 4/28/22 | | 46 YRS | | | | | 11-18 1968 7:30 PM | |
| 7a BIRTH-PLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | |
| Baltimore, Md. | | U.S. | | | | Baltimore | | Md. | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Arbutus | | 5513 Heatherwood Rd. | | | | Soldier-National Guard | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3e STREET AND NUMBER | | |
| Md. | | Baltimore | | Arbutus | | | | 5513 Heatherwood Rd. | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15 MOTHER'S MAIDEN NAME | | | First Middle Last | |
| Sebastian | | | Tuerk | | | Agnes Roettger | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | |
| Yes. Navy WW 2 | | 219-05-6461 | | Angela Cincibus Tuerk, wife, above | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Disease | | | | | | | | | | SUDDEN |
| 4127 | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| Multiple Sclerosis | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | |
| CAUSE OF DEATH | | 19 | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home farm street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED 11/19/68 | | |
| EXAMINER'S NAME (Type) James N. Frederick | | ADDRESS (Street, city, town, or county) 1311 Francis Ave Balto. Md. 21223 | | | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 11/22/68 | | Balto. Nat. Cem. | | Baltimore, Md. | | | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | |
| Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | | NOV 21 1968 | | | | | | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

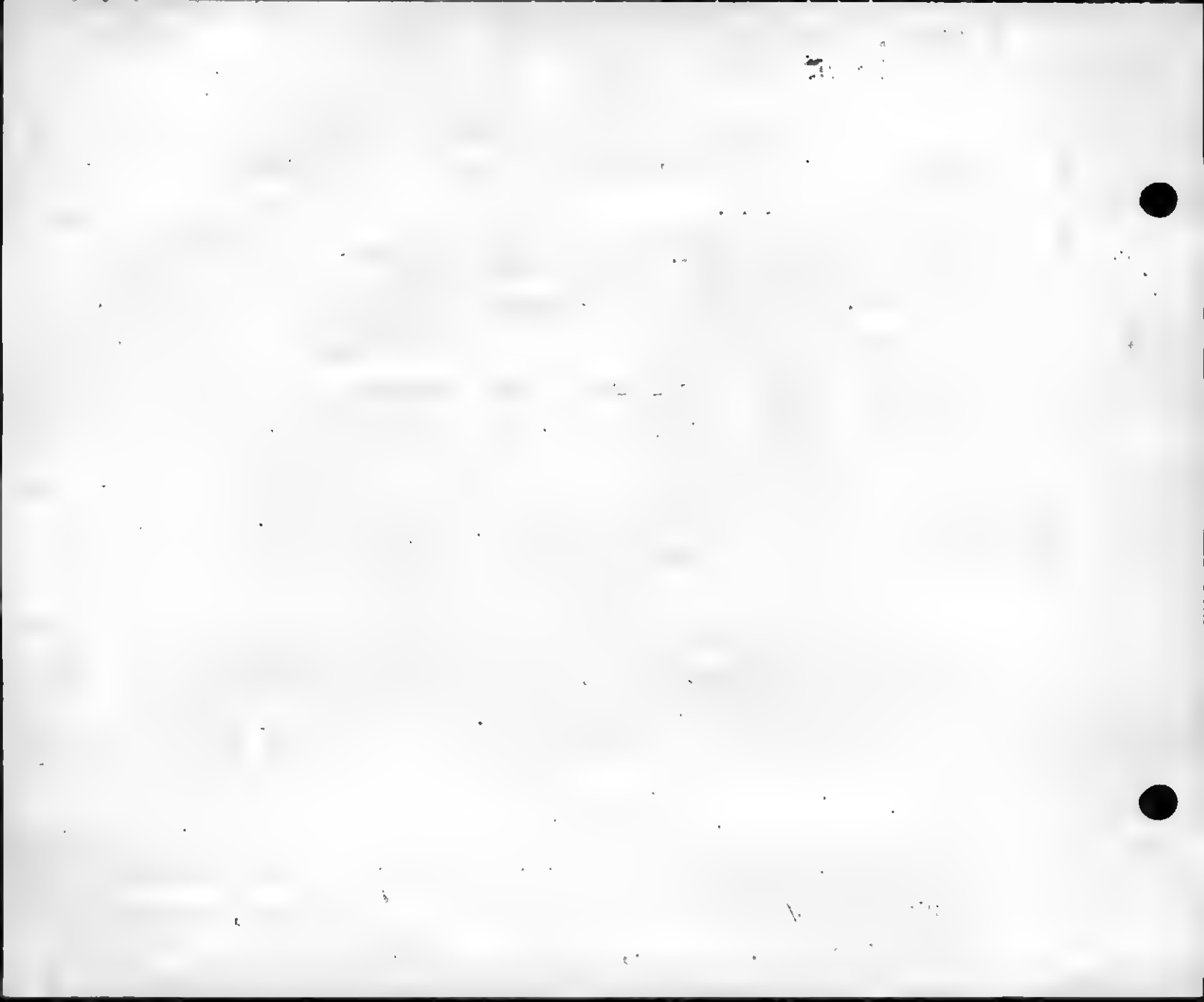
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15694

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15708

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1 DECEASED-NAME (Type or Print) AGNES | | | First Middle Last | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year November 27 1968 | | | 2b. HOUR OF DEATH 6:15 P.M. | | |
| 3 SEX Female | | | 4 RACE White | | | 5 DATE OF BIRTH August 20, 1882 | | | 6 AGE (In years last birthday) 86 YRS | | |
| 7a BIRTH-PLACE (State or foreign country) Baltimore | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Baltimore | | |
| 10 CITY OR TOWN OF DEATH Towson | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD. | | | 13b COUNTY Parkville | | | 13c INSIDE CITY, MARYLAND? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET AND NUMBER 8429 Old Harford Rd. | | |
| 14. FATHER'S NAME Jehn | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME Elizabeth | | | First Middle Last ? | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b SOCIAL SECURITY NO 215-54-1520 | | | 17. INFORMANT Miss Marie Aloisi | | | ADDRESS Same | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure Sudden DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: Coronary Arteriosclerosis 10+ yrs. (b) Fracture of Left Femur 9 Days DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of Left Femur 9 Days | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> | | | | | | 21b TIME OF INJURY Month, Day Year 10 Nov 18 1968 | | | | | |
| 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fallen on Floor in Home | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | 21e PLACE OF INJURY (At home, farm street, factory, office building, etc.) At Home | | | | | |
| 21f LOCATION Street or R.F.D. No 8429 Old Harford Rd | | | | | | City or Town Baltimore County MD State | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) 2127 | | | | | |
| 23a BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial | | | | | | 23b DATE 11/30/68 | | | | | |
| 23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk | | | | | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | |
| 24 FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland | | | | | | ADDRESS | | | | | |
| 25a REC'D BY REG STRAR NOV 29 1968 | | | | | | 25b REG STRAR'S SIGNATURE John J. Judge | | | | | |

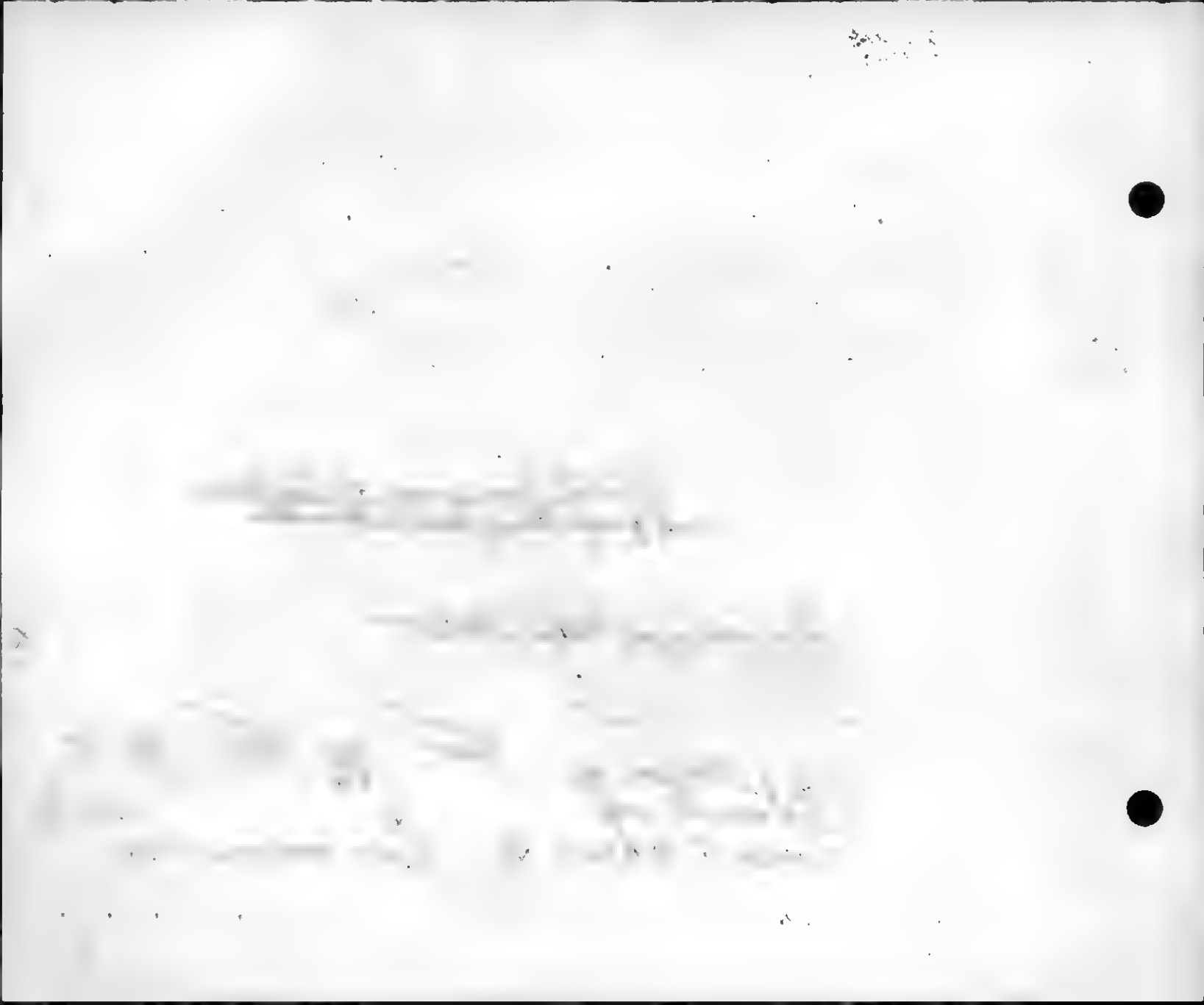


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15695
CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baynesville 21234</u> | | c. LENGTH OF STAY IN 1b <u>Baynesville 21234</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2500 E. Joppa Road</u> | | e. STREET ADDRESS <u>2500 E. Joppa Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>First Thomas E. Turnbaugh</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1968</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>November 20, 1882</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker-retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Estate Work</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Turnbaugh</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Corkran</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Family records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rectal Carcinoma c. metastasis and perforation of bowel into scrotum.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>13+ Generalized debilitation</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Mar</u> | 20f. (City or town) (County) (State) <u>Noo</u> <u> </u> <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>60</u> to <u>Noo</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov 21</u> , 19 <u>68</u> , and that death occurred at <u>8:20</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Frank T Kasik Jr</u> | | 22b. DATE SIGNED <u>11/23/68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR</u> | | 22d. ADDRESS <u>9005 HARFORD Rd</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov. 25, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Parkville, Balto., Co., Md.</u> |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>NOV 26 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4-30M REV. 1-65)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Josie | | | Turner | | | November 20, 1968 | | | 3:20 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | 7. YRS. |
| female | | Negro | | 5-00-89 | | | 79 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Virginia | | U.S.A. | | | | | Baltimore County Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Catonsville | | | Spring Grove State Hospital | | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore City | | | | | 5508 Cadillac Avenue | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| (dec'd) Thomas Johnson | | | Caroline | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| | | | 215-56-1127 JI | | | Records: Spring Grove State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart Failure | | | | | | | | | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause | | | | | | | | | |
| (b) Intermedullary Heart Disease | | | | | | | | | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Generalized Intermedullary | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4. Secondary | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from October 11, 1968, to Nov 20, 1968, that (I) (we) last saw the deceased alive on Nov 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. Trujillo M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED Nov 24/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) E.M.LIC A. TRUJILLO | | | | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL, BALTIMORE, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/24/68 | | | | Warsaw, Virginia | | | |
| 24. FUNERAL DIRECTOR Wm C March 928 E. North Ave. Balto., Md | | | | | 25a. REC'D BY REGISTRAR NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

100

100

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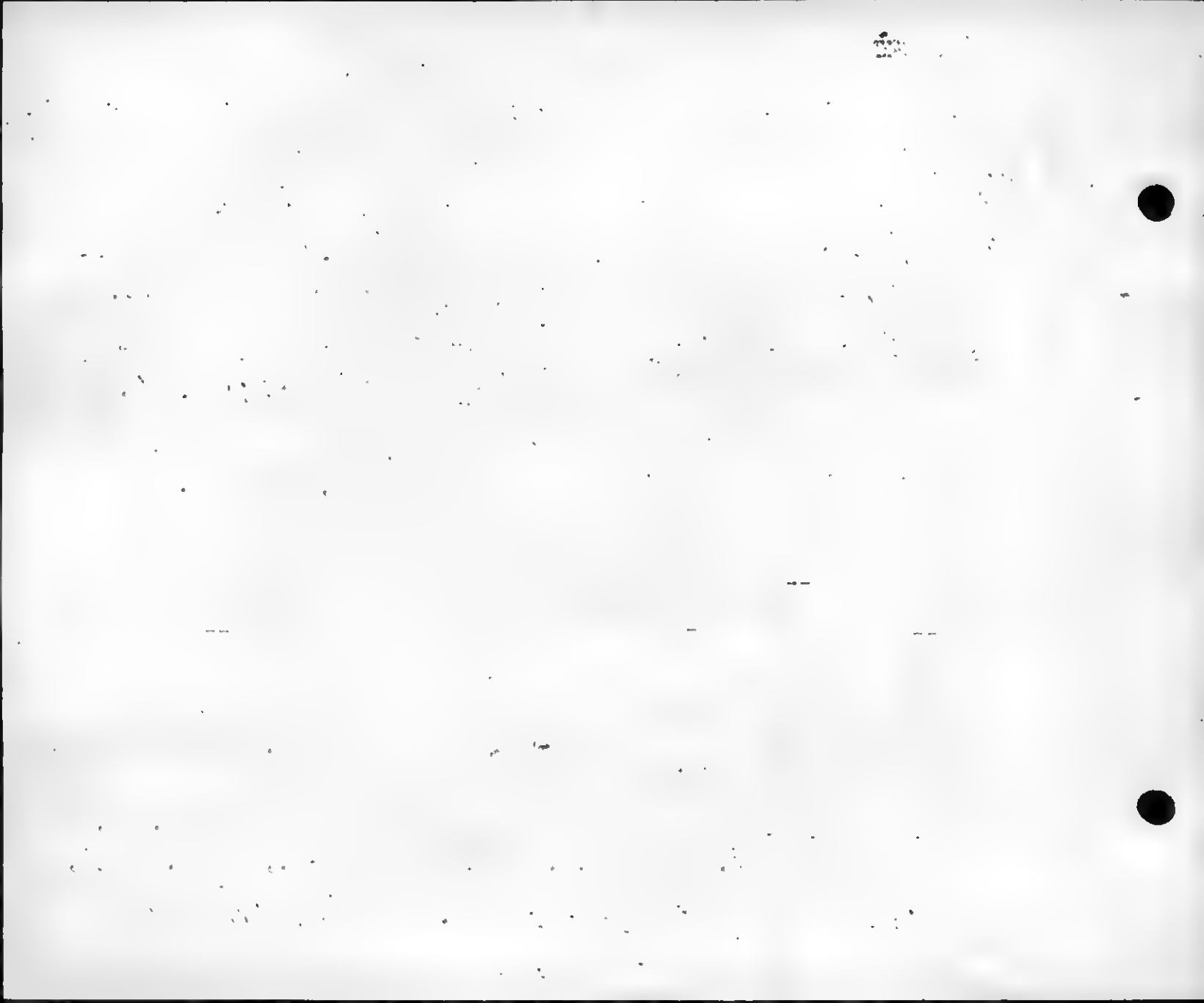
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15697

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) <i>Lena</i> First <i>Violi</i> Middle <i>Lioli</i> Last | | | 2a. DATE OF DEATH Month <i>Nov</i> Day <i>14</i> Year <i>68</i> | | | 2b. HOUR <i>1 P.M.</i> | | | |
| 3 SEX <i>F</i> | | 4 RACE <i>W.</i> | | 5 DATE OF BIRTH <i>Dec. 21</i> | | 6 AGE (In years) <i>28</i> YRS. | | IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN. | |
| 7a. BIRTHPLACE (State or foreign) <i>Baltimore</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Balto.</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Berry Hall</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9409 Belair Road</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY — | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY <i>Berry Hall</i> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>9409 Belair Rd.</i> | | | |
| 14. FATHER'S NAME First <i>Stuslav</i> Middle <i>Hiebel</i> Last | | | | 15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>21236</i> Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT <i>Peter Lioli</i> Address <i>9409 Belair Rd</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis, advanced.</i> Cand trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>4400</i> — | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) — | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) did not attended the deceased from <i>Oct. 18</i> , 19 <i>68</i> , to <i>Nov. 14</i> , 19 <i>68</i> , that (I) was last saw the deceased alive on <i>Nov. 14</i> , 19 <i>68</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Theodore E. Evans</i> M.D. DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>Nov. 15, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Theodore E. Evans, M.D.</i> | | | | 22e. ADDRESS <i>9660 Belair Rd., Balto. 21236, Md</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC. | | 23b. DATE <i>11/18/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i> | | 23d. LOCATED ON (City or Town) (County) (State) <i>Balto Md</i> | | | |
| 24. FUNERAL DIRECTOR <i>P. H. Heermann</i> | | | | ADDRESS <i>6067 Hay Rd</i> | | 25a. REC'D BY-REGISTRAR DATE <i>11 15 68</i> | | 25b. REGISTRAR'S SIGNATURE <i>Jorge</i> | |



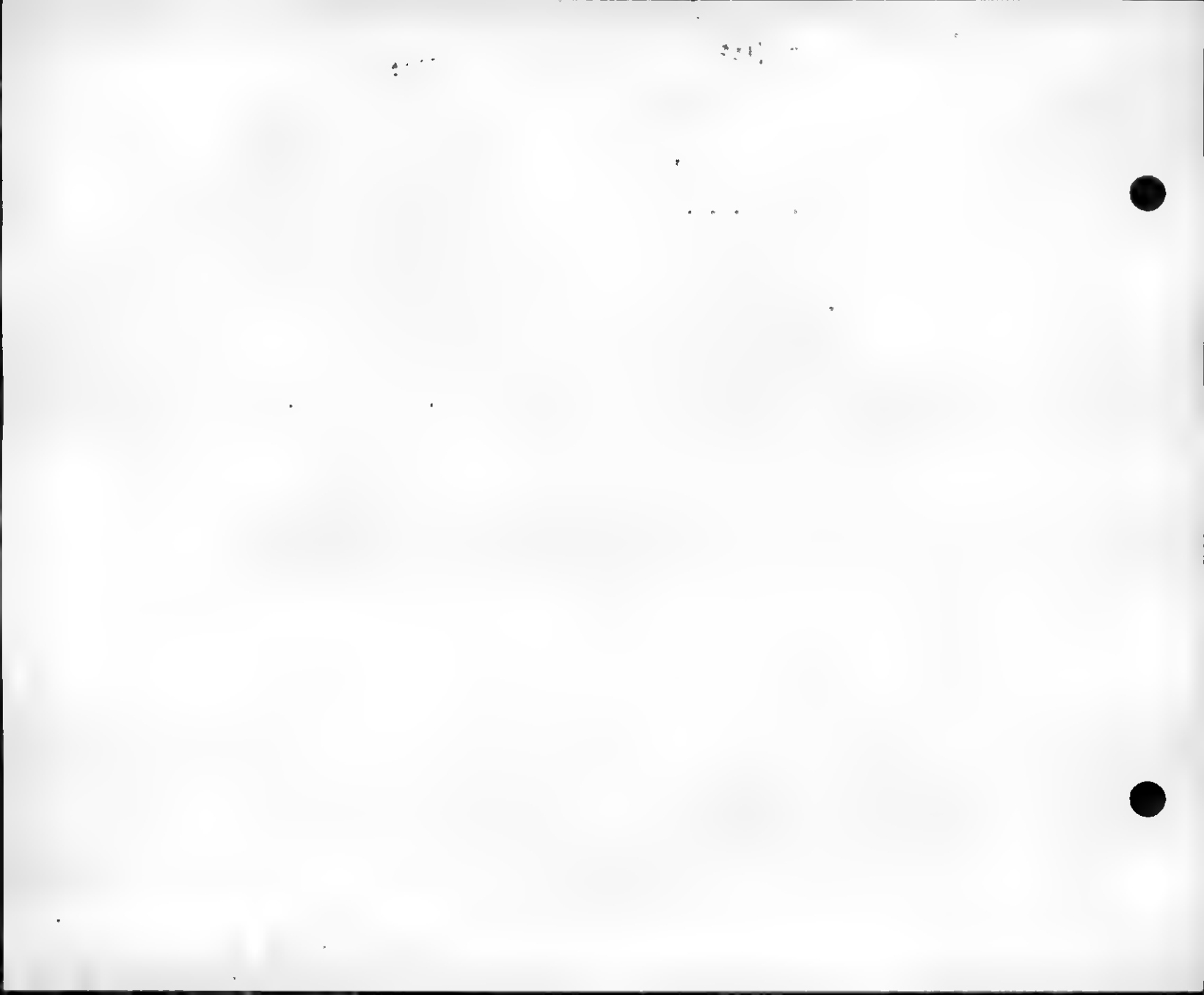
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15698

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

15712

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED NAME (Type or print) | | First Maude | | Middle Evelyn | | Last Wallace | | 2a. DATE OF DEATH Month 11 Day 5 Year 1968 | | 2b. HOUR M | |
| 3 SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH 2-14-1888 | | 6 AGE (in years last birthday) 80 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Dorchester Co. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH Woodcroft | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodcroft | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 2423 Ellis Road 34 | | | |
| 14. FATHER'S NAME First Carroll | | Middle Carroll | | Last Carroll | | 15. MOTHER'S MAIDEN NAME First Sarah | | Middle Sarah | | Last Sarah | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO No | | 17 INFORMANT Howell F. Wallace Sr. | | Address 6658 Loch Hill Road | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/1/68 , 19__, to 10/28/68 , 19__, that (I) (we) last saw the deceased alive on 10/28/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Joseph D'Antonio MD | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 11/6/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Joseph D'Antonio | | 22e. ADDRESS 100 N. Broadway Baltimore Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-8-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City or Town) Baltimore | | (County) City | | (State) Md. | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home | | ADDRESS 7401 Belair Road | | 25a. REC'D BY REG STRAR NOV 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



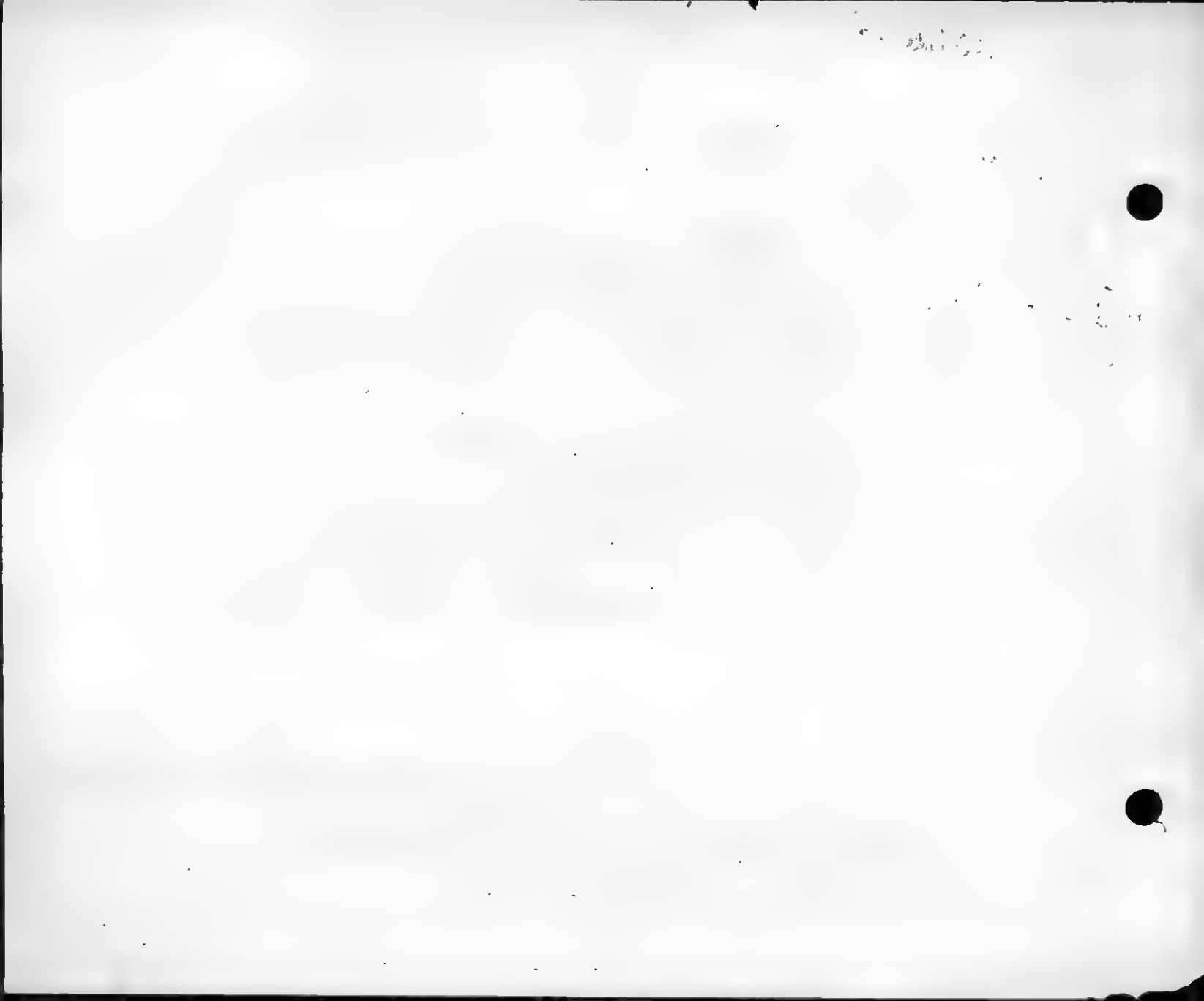
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15699 **CERTIFICATE OF DEATH** **15713**

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u> | | c. LENGTH OF STAY IN 1b <u>34 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Walters Lane</u> | | d. STREET ADDRESS <u>Walters Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Templeton</u> Last <u>Walters</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1968</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 17, 1902</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Foreman Tools</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tools</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Harry R. Walters</u> | | 14. MOTHER'S MAIDEN NAME <u>Daisy B. Schoppert</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-104012</u> | |
| 17. INFORMANT <u>F. MARIE Walters</u> | | Address <u>SPARKS, Maryland</u> | |

| | | | | |
|---|---|--|--------------------------------------|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4111 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CORONARY Atherosclerosis</u> DUE TO (c) <u>ARTERIOSEPTIC CARDIASC. DIS</u> | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/16/59</u> to <u>25 Sept</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>25 Sept 1968</u> , and that death occurred <u>12:50 AM</u> , from the causes and on the date stated above. | | | | |
| 22a. SIGNATURE <u>Donald O. Wood M.D.</u> | | 22b. DATE SIGNED <u>11/25/68</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>DONALD O. WOOD, M.D.</u> | | 22d. ADDRESS <u>York Road and Greenmeadow Dr. Timonium, Maryland 21093</u> | | |

| | | | |
|---|--|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Nov 26, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery Parkton Balto Co. Md.</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR <u>James J. Hartenstein, New Freedom, Pa.</u> | | 25a. REC'D BY REGISTRAR <u>g. Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>g. Charles Judge</u> | | DATE <u>NOV 27 1968</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15700

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15714

| | | | | | | | | | | | | |
|--|---------------------|--|---|---|--|---|---|--|--|--|-----------------------------|---------|
| 1. DECEASED-NAME (Type or Print) Frank A Warner | | | 2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> M | | | 2b. HOUR M | | | | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 5-27-98 | 6. AGE (in years last birthday) 70 YRS. | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month 11 Day 21 Year 1968 | | | 2d. HOUR 7 P.M. | | | |
| 7a. BIRTHPLACE (State or foreign country) Pittston Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethlehem Steel-Sparrows Pt Labor | | | 12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Steel | | | 12b. KIND OF BUSINESS OR INDUSTRY Steel | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1327 Bethlehem Avenue | | | |
| 14. FATHER'S NAME First unknown Middle unknown Last unknown | | | 15. MOTHER'S MAIDEN NAME First unknown Middle unknown Last unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) unknown | | 17. INFORMANT Mrs Frank Warner | | ADDRESS 1327 Bethlehem Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Rith Lung DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD 163 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 <input type="checkbox"/> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis | | | M.D. M.B. Davis, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 11-21-68 | | | |
| EXAMINER'S NAME (Type) 6800 Morningson Road, 21222 | | | Dundalk, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11-25-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery | | | 23d. LOCATION (City or Town) Baltimore | | | (County) Maryland | (State) |
| 24. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

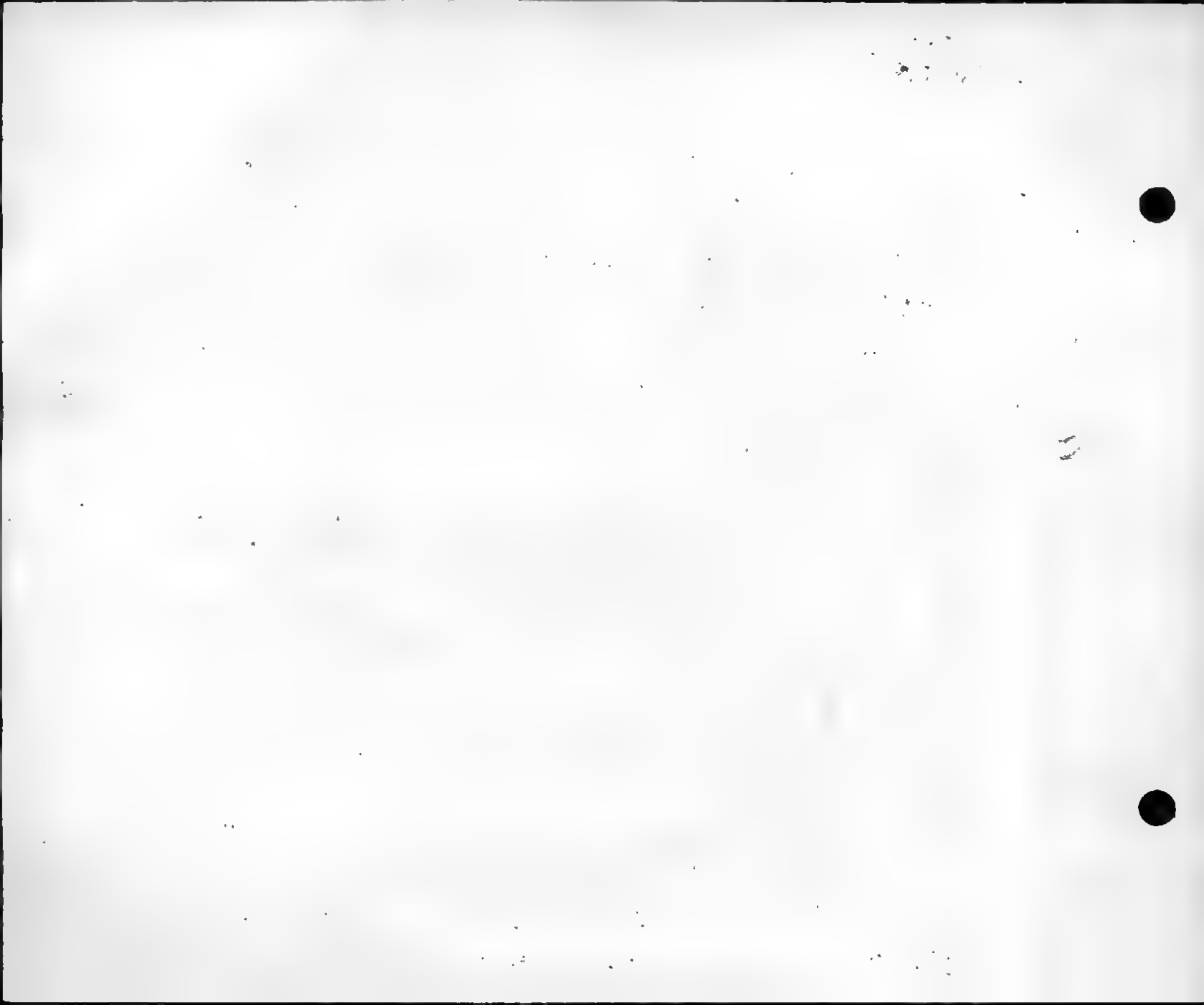


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

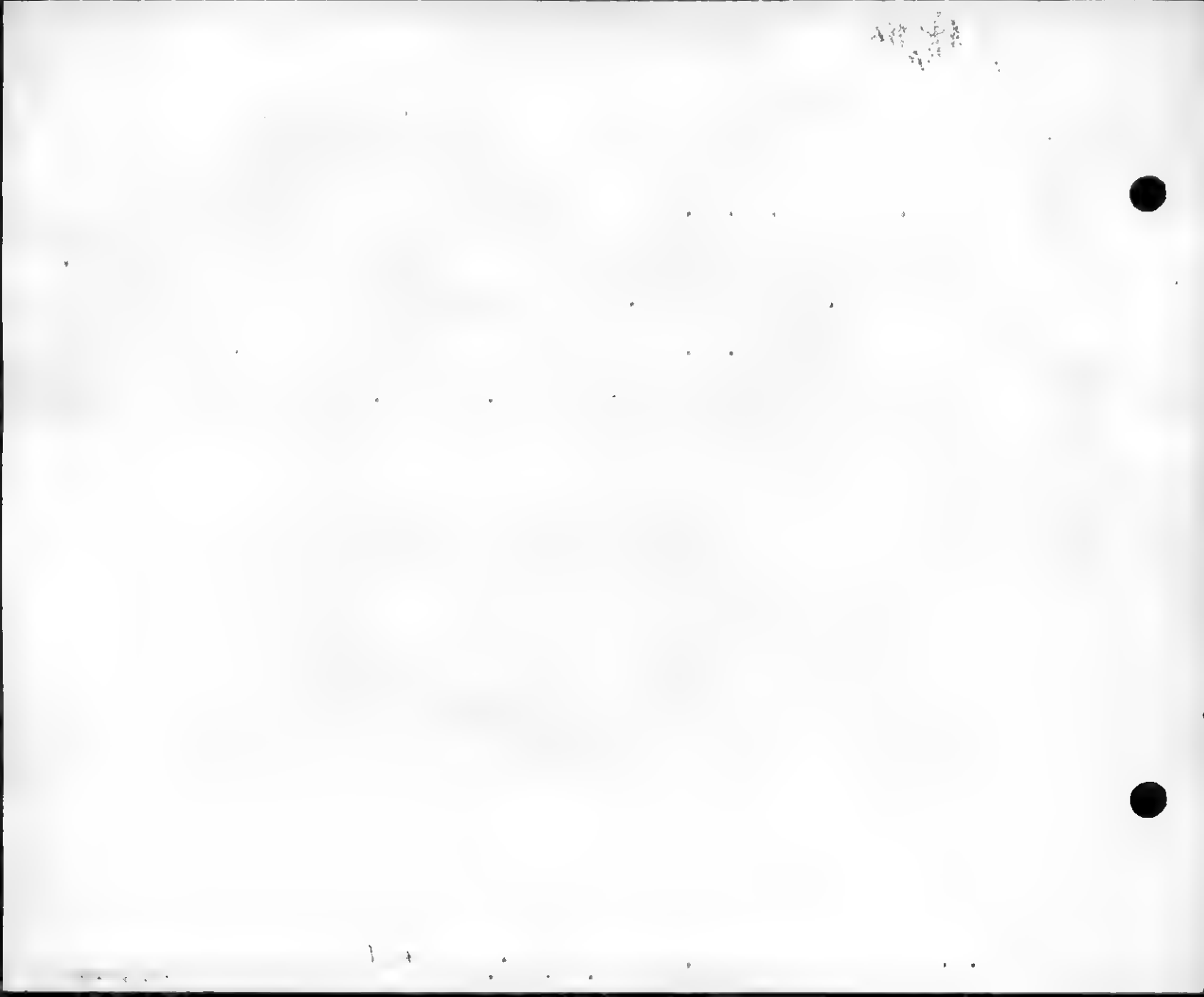
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--------------|--|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 15701 | | | | | | | | | | | | |
| Item 23 a Film G 407 12/6/68 JW | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Mary | | | Carter | | | Watson | | | Month Day Year | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | |
| Female | | | White | | | 12/11/1897 | | | 70 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| Virginia | | | U.S. | | | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Catonsville | | | Spring Grove State Hosp | | | Housewife | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | |
| Md. | | | Prince George | | | Hyattsville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | | | | |
| deceased (unknown) | | | deceased (unknown) | | | 7400 Tilden St. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 235-17 | | | Record | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac ARREST.</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic GENERALIZED Heart disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4200</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>67</u> , to <u>10/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | |
| 22c. DATE SIGNED | | | | | | | | | | 10/30/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | | |
| EVELIO A. FELIPE MD | | | | | | | | 3 BSA | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | DEC 3-1968 | | | MASONIC | | | Middleway Jefferson W.M. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Stricker | | | | | | Charlestown Va | | | DEC 1 1968 | | J. J. Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|---|---|---|--|--|---|--|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Sidney | | | Watters, Sr. | | | Nov. 7, 1968 | | | 7 40 AM |
| 3 SEX | M | | 4. RACE | W | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | 8 YRS |
| | | | | | | 3/16/1886 | | 82 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. | | U. S. A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Monkton | | | Manor Road | | | Tax Agent | | State of Md. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER | | |
| Md. | | | Balto. | | Monkton | | | Manor Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| William J. H. Watters | | | Mary L. Nicodemus | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | |
| Yes | | | WWI | | 212-09-4279 Mrs. Louis P. Watters (Same) | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> | | | | | | | | | 1968 |
| 165X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 177X | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| <u>Empty Sema</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5, 1968</u> to <u>Nov. 7, 1968</u> , that (I) (we) last saw the deceased alive on <u>Nov. 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Walter T. Kees</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>7 November 1968</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u> | | | | | 22e ADDRESS <u>Cockeyville, Md 21030</u> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/9/68 | | Greenmount | | Baltimore Md. | | | |
| 24 FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | | | | | 25a REC'D BY REGISTRAR <u>NOV 8 1968</u> | | 25b REGISTRAR'S SIGNATURE <u>J. Charles Young</u> | | |
| 4905 York Rd. Balto. 12, Md. | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 74 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

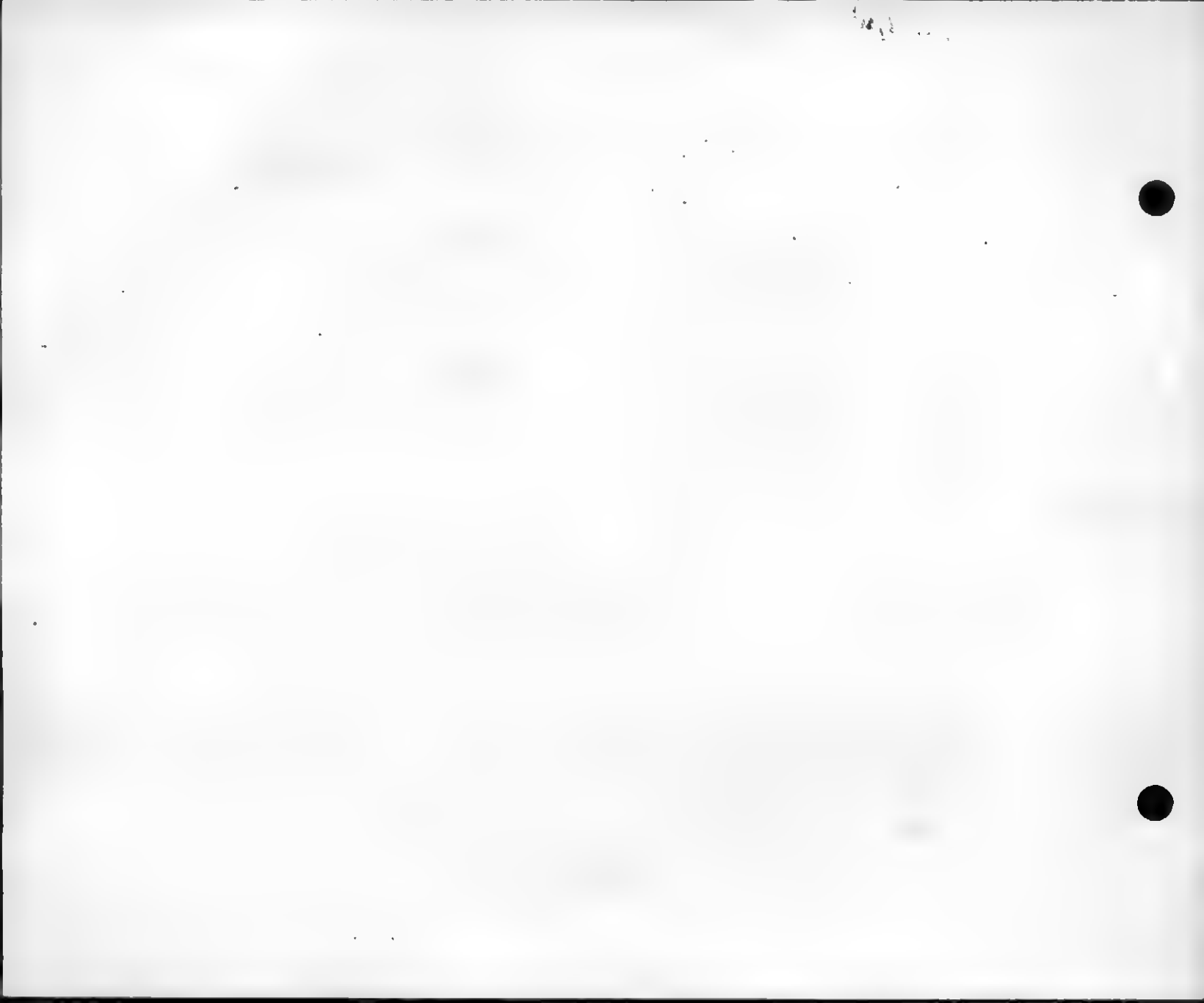
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15702

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15711

| | | | | | | | | |
|--|------------------------|---|---|--|--|--|---|---|
| 1 DECEASED NAME (Type or Print) ARTHUR Gorman Weber | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> NOV 25 1968 | | | 2b HOUR 5:30 PM | | |
| 3 SEX MALE | 4 RACE White | 5 DATE OF BIRTH NOV 3, 1905 | 6 AGE (in years last birthday) 63 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month Nov Day 25 Year 1968 | | |
| 7a BIRTHPLACE (State or foreign country) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore | | |
| 10. CITY OR TOWN OF DEATH BALTO 21234 Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Putty Hill | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pharmacist | | 12b KIND OF BUSINESS OR INDUSTRY Pharm. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | 13b COUNTY Balto | | 13c CITY OR TOWN Parkville | | 13e. STREET AND NUMBER 2932 Putty Hill 21234 | |
| 14 FATHER'S NAME First Middle Last OTTO Emil Weber | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mabel Estelle Black | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16b SOCIAL SECURITY NO 216-01 4768 | | 17. INFORMANT ADDRESS Wife same 2932 Putty Hill 21234 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Circumstances of hanging. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Emphysema | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or RFD No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John C. Hyle | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED 11-25-68 | | |
| EXAMINER'S NAME (Type) JOHN C. Hyle | | | ASS STANT MED CAL EXAMINER <input type="checkbox"/> | | | DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) 527 Baltimore | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE 11-29-68 | | 23c NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d LOCATION (City or town) (county) (State) BALTO CO MD | | |
| 24. FUNERAL DIRECTOR C. F. EVANS & SON 8802 HARFORD ROAD | | | | 25a REC'D BY REGISTRAR DATE NOV 26 1968 | | 25b REGISTRAR'S SIGNATURE [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14,
45M 1/69

| 15706 | | | | | | | | | | | | 1571 | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|------------------------|--|--|--|-----------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | | | | | | | |
| ERNEST | | | | FRED | | | | WEBER | | | | Month Day Year NOVEMBER 9, 1968 | | | | 6:30 PM | | | | | | | |
| 3 SEX | | | | 4 RACE | | | | 5 DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS | | | |
| MALE | | | | CAUCASIAN | | | | JANUARY 29, 1897 | | | | 71 YRS | | | | MONTHS DAYS HOURS MIN | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH | | | | | | | | | | | |
| IOWA | | | | U.S.A. | | | | | | | | BALTIMORE | | | | Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (Give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| FORT HOWARD | | | | VETERANS ADMINISTRATION | | | | TRUCK DRIVER | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER | | | | | | | |
| MARYLAND | | | | DORCHESTER | | | | CAMBRIDGE | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 205 SUNBURST HIGHWAY | | | | | | | |
| 14 FATHER'S NAME | | | | First Middle Last | | | | 15 MOTHER'S M A D E N NAME First Middle Last | | | | | | | | | | | | | | | |
| HARRY | | | | J WEBER | | | | CAROLINE | | | | GERBER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | Address | | | | | | | | | | | |
| YES | | | | WW I | | | | 202 32 0545 | | | | CLINICAL RECORDS VA HOSP., FT HOWARD, MD | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BI-LATERAL BRONCHO-PNEUMONIA</u> | | | | | | | | | | | | 5 DAYS | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>GRAM-NEGATIVE SEPTICEMIA</u> | | | | | | | | | | | | 6 DAYS | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED DUODENAL ULCER</u> | | | | | | | | | | | | 6 DAYS | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | |
| <u>POST-OP RIGHT UPPER LOBECTOMY FOR CANCER OF LUNG</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | YES | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>10/2/68</u> , 19 <u>68</u> , to <u>11/9/68</u> , 19 <u>68</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>11/9/68</u> , 19 <u>68</u> , and that in <u>(our)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>XX</u> (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| | | | | | | | | | | | | 11 10 68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| KRISHNA V.S. RAO, M.D. | | | | VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | |
| BURIAL | | | | Nov 12 1968 | | | | East New Market Cemetery | | | | East New Market, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| LECOMPTE FUNERAL HOME, HIGH ST, CAMBRIDGE, MD | | | | | | | | DATE NOV 13 1968 | | | | Charles Judge | | | | | | | | | | | |

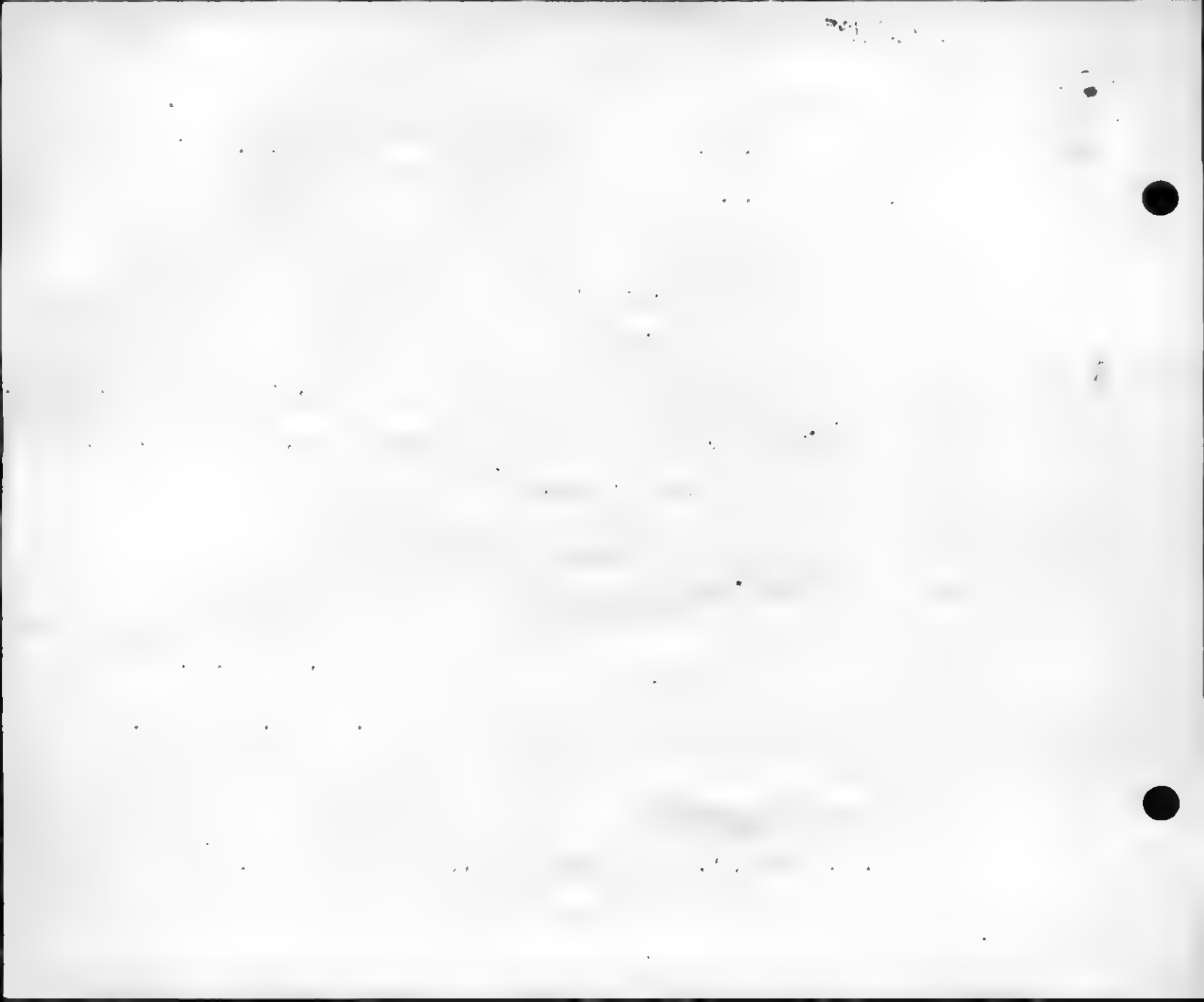


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in permit item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME (Type or Print) | | First Sofie | | Middle - | | Last Weikers | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Nov. Day 18 Year 1968 | | 2b HOUR 7 a M | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH Jan. 13, 1915 | | 6 AGE (in years last birthday) 53 YRS | | 7 UNDER 1 YEAR MONTHS _____ DAYS _____ | | 7c DATE PRONOUNCED DEAD Month Nov. Day 18 Year 1968 | |
| 7a BIRTHPLACE (State or foreign country) Germany | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Baltimore Md | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore 21209 | | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 6611 Amleigh Road | | | | 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER 6611 Amleigh Road | |
| 14 FATHER'S NAME First Louis | | | | Middle Weikers | | Last Bertha | | 15 MOTHER'S MAIDEN NAME First Levi | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b SOCIAL SECURITY NO - | | 17 INFORMANT ADDRESS Mrs. Louise Sandler, 6611 Amleigh Rd., Balto. Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage due to cut throat, wrists, elbows and left leg. DUE TO, OR AS A CONSEQUENCE OF (b) Mental Depression DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. (est) 2½ mos. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Mental depression | | | | | | | | | | | |
| 19a DATE OF OPERATION Nov. 18 1968 | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Deceased cut wrists, elbows, L. leg and throat | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year Nov. 18 1968 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased cut wrists, elbows, L. leg and throat | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f LOCATION Street or RFD No 6611 Amleigh Rd., Balto. | | City or Town Balto. | | County Balto. | | State Md. | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED 11-19-68 | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street or RFD No, City or Town, County, State) 6 Hanover Rd., Reisterstown, Md. 21136 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 11/19/68 | | 23c NAME OF CEMETERY OR CREMATORY Chesapeake Chapel | | 23d LOCATION (City or Town) Reisterstown | | County Md | | State | |
| 24 FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc | | | | ADDRESS 9610 Reisterstown Rd | | | | 25a REC'D BY REGISTRAR NOV 20 1968 | | 25b REGISTRAR'S SIGNATURE [Signature] | |

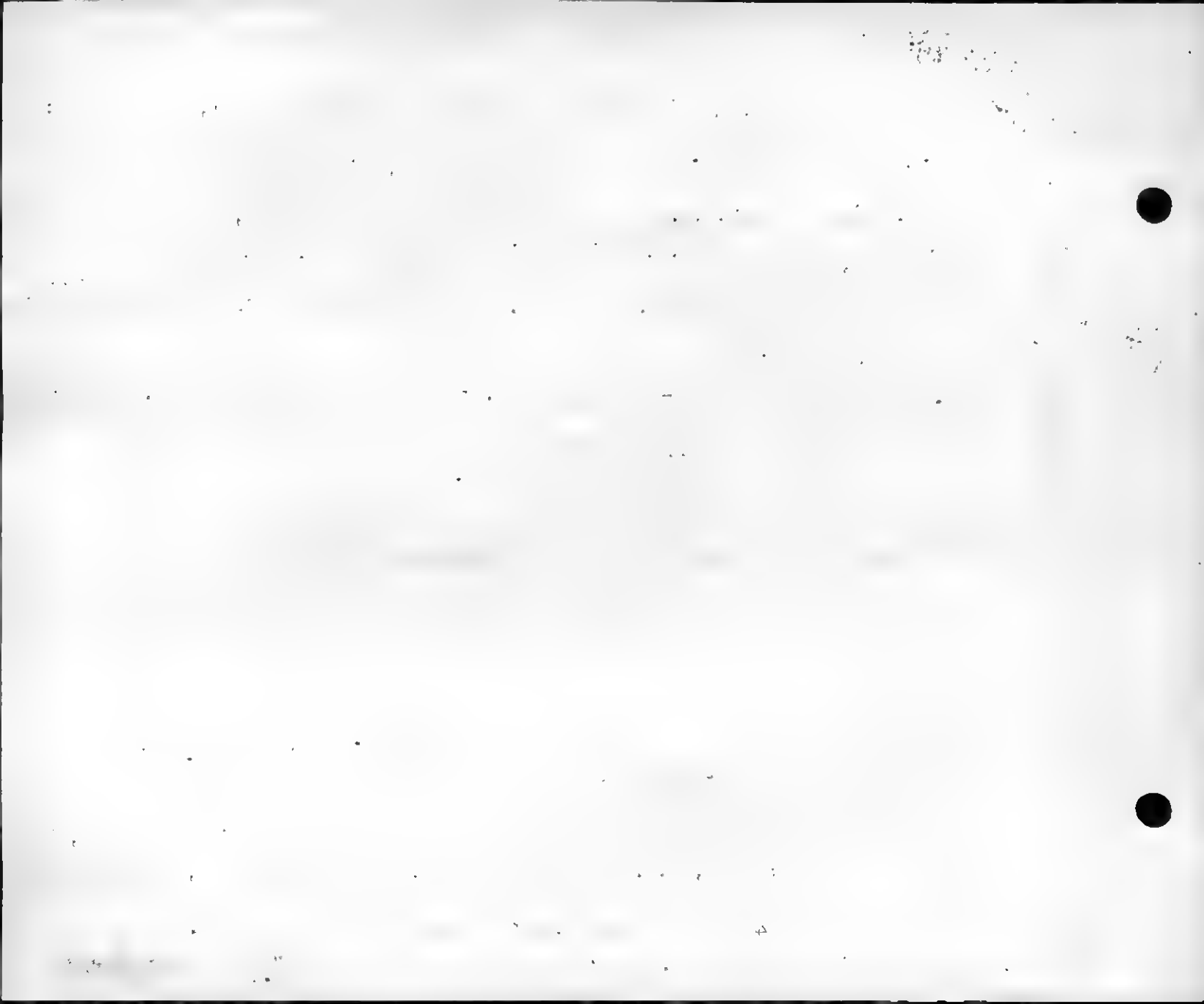


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| <div>15705</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>15720</div> | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|----------------------------------|----------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First ANNA | | | Middle LORETTA | | | Last WENGER | | | 2a. DATE OF DEATH NOVEMBER Month 11, Day 1968 | | | 2b. HOUR 11:45 PM | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH OCTOBER 21, 1893 | | | 6. AGE (In years last birthday) 75 YRS. | | | 7. UNDER YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE | | | Md | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life; has been retired) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND | | | 13b. COUNTY Balto. | | | 13c. CITY OR TOWN Balto. | | | 13d. INSIDE CITY LMA 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 5020 BALTIMORE NATIONAL PIKE #21229 | | | | | |
| 14. FATHER'S NAME First Middle Last Jacob Wenger | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Helene | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO --- | | | 17. INFORMANT Mrs. Margaret Wenger, 5020 Balto. Natl Pike | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4510 DUE TO, OR AS A CONSEQUENCE OF ESSENTIAL HYPERTENSION. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 11, 1968, to NOVEMBER 11, 1968, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on November 11, 1968 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (decide) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lorna Gaudiol | | | | | | | | | | | | 22c. DATE SIGNED November 12, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Lorna Gaudiol, M.D. | | | | | | 22e. ADDRESS 7620 York Road Towson, Maryland #04 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/14/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229 | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 12 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

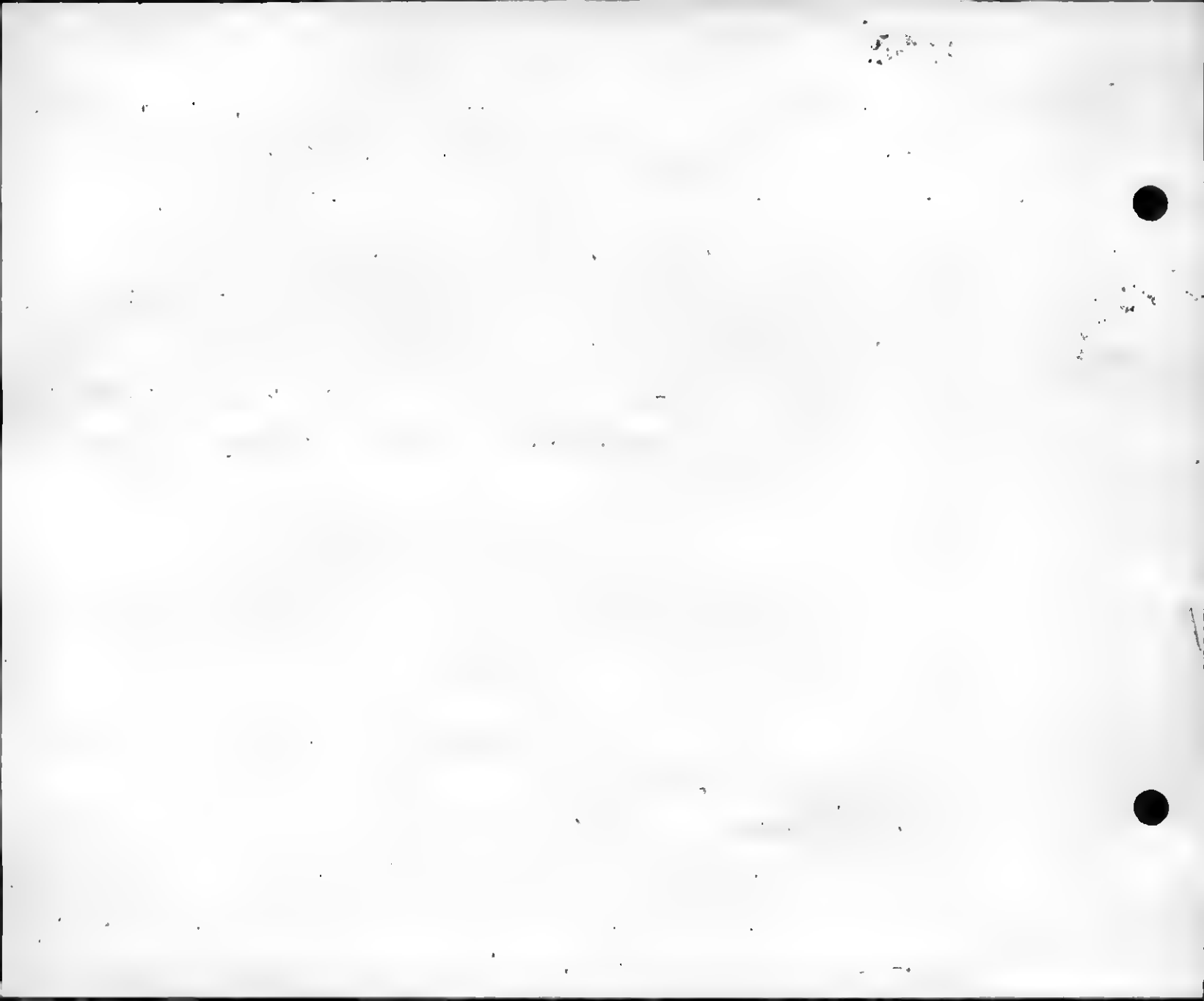
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15721

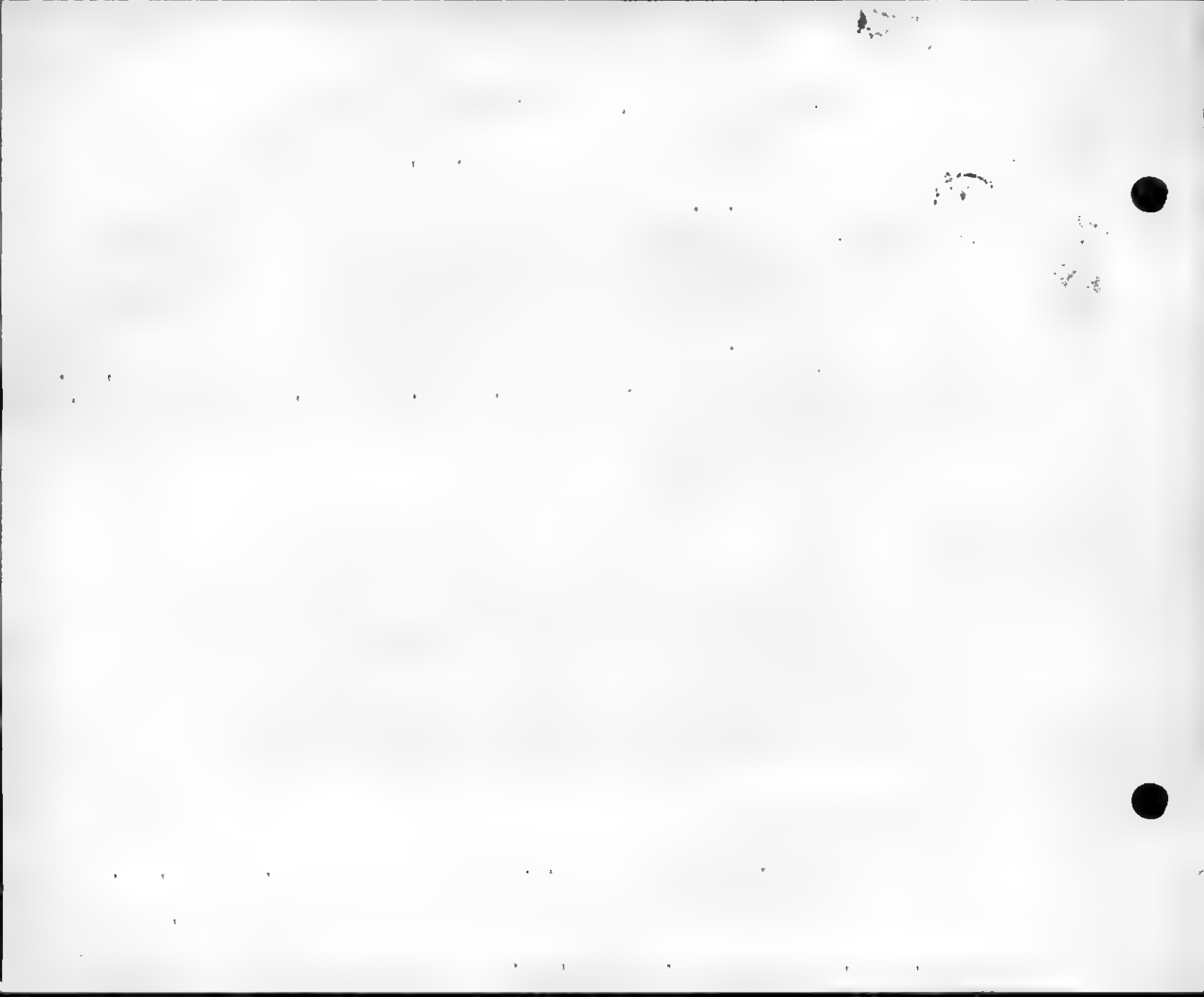
| | | | | | | | | |
|--|------------------------------|--|---|---|---------------------------------|--|---|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mattie | | Lou | Wheeler | Nov. 10, 1968 | | 8-24 M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| female | white | | October 31, 1881 | | 87 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| West Va. | USA | | | | Baltimore | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| | | 1200 Wakeford Circle | | Homemaker | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | Balto. | | | | 13e. STREET AND NUMBER 1200 Wakeford Circle | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | |
| Rufus Martin Wheeler | | Agnes Elizabeth Moore | | no | | 220-46-2603 | | |
| 17. INFORMANT | | 17. ADDRESS | | 17. INFORMANT | | 17. ADDRESS | | |
| Mrs. Betty Dickinson | | 1200 Wakeford Circle #12 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 27, 1959</u> to <u>Nov 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>November 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. ADDRESS | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | |
| Dr. E. J. Alessi | | 11/11/68 | | 6217 Harford Road | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| burial | | 11/12/68 | | Riverview | | Strasburg, Virginia | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Mitchell-Wiedefeld Home 6500 York Rd. #21212 | | | | DATE NOV 18 1968 | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

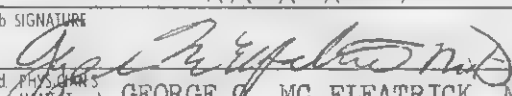

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the permit, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Francis | | | Middle C. | | | Last Wienhold | | | 2a. DATE OF DEATH Month November Day 22 Year 1968 | | | 2b. HOUR 7:34 AM | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH Sept. 30, 1913 | | | 6. AGE (In years last birthday) 55 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH Dundalk | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6811 Bessemer Avenue | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) Machinist | | | 12b. KIND OF BUSINESS OR INDUSTRY Armco Steel | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Dundalk | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 6811 Bessemer Avenue | | | | |
| 14. FATHER'S NAME | | | First Charles | | | Middle E. | | | Last Wienhold | | | 15. MOTHER'S MAIDEN NAME First Caroline Middle Deckret Last Deckret | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 213-09-1439 | | | 17. INFORMANT (Wife) Mrs. May E. Wienhold, 6811 Bessemer Ave. | | | Address Dundalk, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho-Sarcoma 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION Sept 1968 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Block in Neck | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 21, 1968 to Nov 21, 1968 , that (I) (we) last saw the deceased alive on Nov 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE M.B. Davis | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 11/22/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Melvin B. Davis | | | 22e. ADDRESS 6800 Mornington Rd. Dundalk, Md. 21222 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 11/25/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 25 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15709 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 15723 </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|------------------------|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| JOSEPH | | | | JOHN | | | | WIKARSKI | | | | NOVEMBER 24, 1968 8:30p.m. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| MALE | | WHITE | | 8/9/97 | | | | 71 YRS | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 2c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| FORT HOWARD | | | | VETERANS ADMIN. HOSPITAL | | | | STORE OWNER | | | | HARDWARE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. ASIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| MARYLAND | | | | | | BALTIMORE | | | | 630 SOUTH LAKEWOOD | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S M.A.DEN NAME First Middle Last | | | | | | | | | | | |
| GEORGE - - WIKARSKI | | | | MAGDELINA | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war and dates of service) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | | | | | |
| YES WWII | | | | 216 32 9350 | | CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | | | | | | RECENT | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost 492X | | | | | | | | | | | | OLD | | | |
| (b) PULMONARY EMPHYSEMA | | | | | | | | | | | | | | | |
| (c) COR PULMONALE | | | | | | | | | | | | OLD | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| ARTERIOSCLEROSIS GENERALIZED, OLD | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or RFD No City or Town County State | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from SEP. 4, 1968, to NOV. 24, 1968, that he (we) last saw the deceased alive on NOV. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
|  | | | | | | | | | | | | 11/25/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | | | | | |
| GEORGE C. MC ELPATRICK, M. D. | | VAH, FT. HOWARD, MD. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| BURIAL | | 11/29/68 | | SACRED HEART OF MARY | | | | DUNDALK, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | |
| SADOWSKI & Sons 1808 Eastern Ave BALTIMORE, MD. NOV 27 1968 | | | | | | | | | | | | | | | |
| 25a. REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-154
304a REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15710

CERTIFICATE OF DEATH

15724

| | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|---|---|--|
| 1 DECEASED-NAME (Type or print) SARAH | | First SARAH | | Middle JANE | | Last WILLS | | 2a. DATE OF DEATH Month Nov. Day 29 Year 1968 | | | 2b. HOUR 5:15 M | |
| 3 SEX Female | | 4. RACE White | | 5 DATE OF BIRTH Sept. 7, 1908 | | | 6 AGE (In years last birthday) 60 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | |
| 10 CITY OR TOWN OF DEATH North Point | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8200 Bletzer Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At home | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN North Point | | 3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 8200 Bletzer Road | | | | |
| 14 FATHER'S NAME First John | | Middle Rugemer | | Last | | 15. MOTHER'S MAIDEN NAME First Fannie | | Middle | | Last Smith | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Wm. H. Wills, Jr., | | Address 8200 Bletzer Road | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) A-S-C-V Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 9 yrs. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recurrent Secondary Anemia | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 28, 1959 , to Nov 29, 1968 , that (I) (we) last saw the deceased alive on Nov 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE M.B. Davis | | DEGREE M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) M.B. Davis, M.D. | | 22e. ADDRESS 6800 Morningside Road | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City or Town) Colgate, Md. | | (County) | | (State) | | |
| 24. FUNERAL DIRECTOR William Funeral Home Dundalk, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 3 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |

MEDICAL CERTIFICATION

1877

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 1571A | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First ARTHUR | | | Middle W. | | | Last WINDHEIM | | | 2a. DATE OF DEATH Month 11 Day 26 Year 68 9:00P M | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 10/14/94 | | | 6. AGE (In years last birthday) 74 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) NEW JERSEY | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE COUNTY, Md | | | | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLUMBER | | | 12b. KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN DUNDALK | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 210 PARKWOOD ROAD | | |
| 14. FATHER'S NAME First MIDDLE LAST HENRY WINDHEIM | | | 15. MOTHER'S MAIDEN NAME First MIDDLE LAST MARGARET HESS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES | | | 16b. SOCIAL SECURITY NO WW I 137 09 93 20 | | | 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA | | | | | | | | | | | | RECENT | | |
| 1001 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 16.3 X | | | | | | | | | | | | | | |
| (b) CARCINOMA OF LUNG WITH METASTASIS | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from 11/12/68, 19 to 11/26/68, 19, that (he) (we) last saw the deceased alive on 11/26/68, 19, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Nan Ann Orer M.D., DEGREE | | | | | | | | | | | | 22c. DATE SIGNED 11/27/68 | | |
| 22d. PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D. | | | | | | | | | | | | 22e. ADDRESS VAH FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE 11 30 68 | | | 23c. NAME OF CEMETERY OR CREMATORY EAST RIDGE LAWN CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) DELAWARE, NEW JERSEY | | | | | |
| 24. FUNERAL DIRECTOR Mc Cully | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR JOHNESSEE NUTLEY HOME FOR FUNERAL WASHINGTON AVE. NUTLEY, NEW JERSEY | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE NOV 29 1968 Charles Judge | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 413-1
304 REV. 11-68

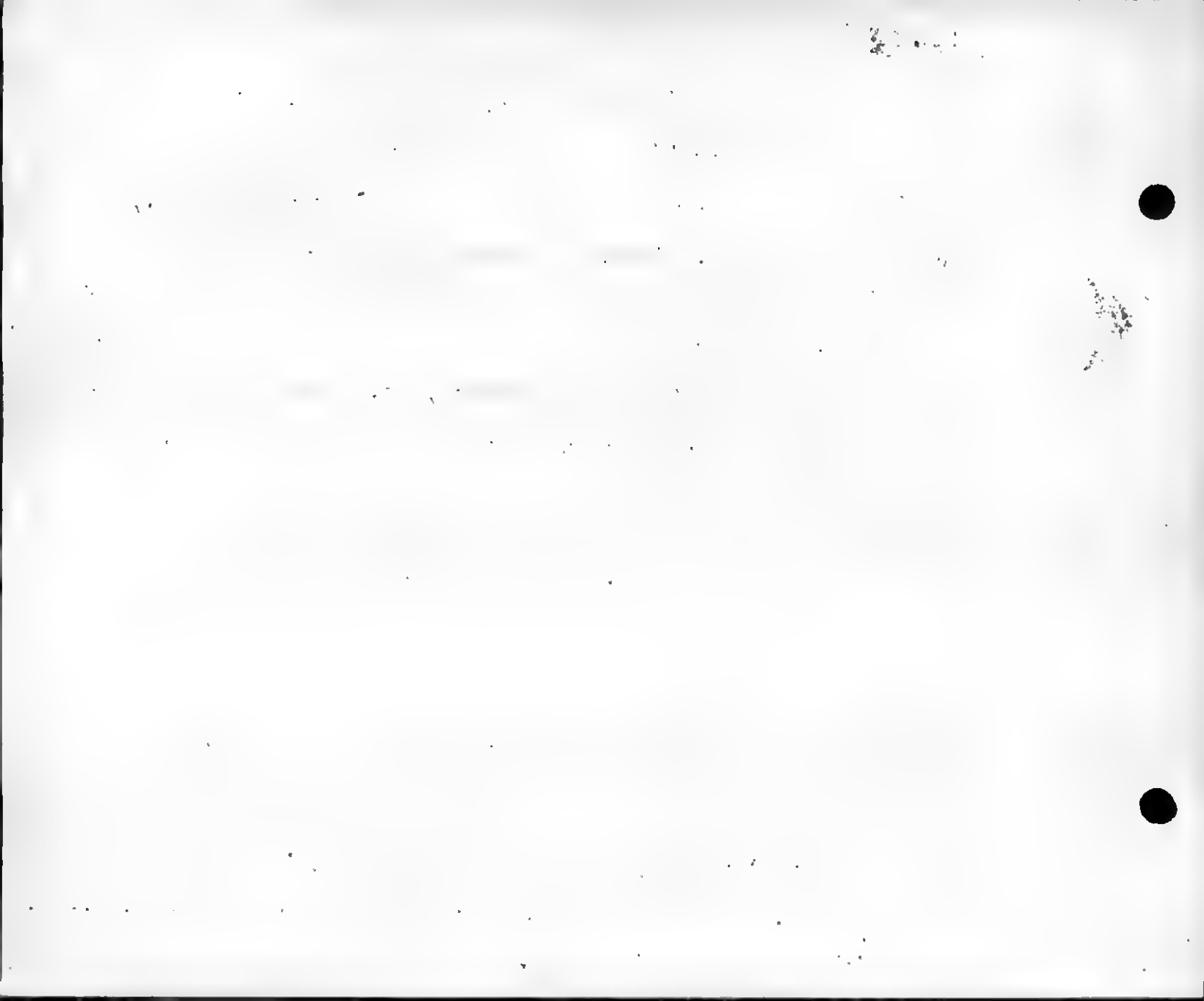
15712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15726

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last <i>William JACOB WINTERS</i> | | | 2a. DATE OF DEATH Month Day Year <i>11 - 30 - 1968</i> | | | 2b. HOUR <i>3:55 P.M.</i> | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>10/7/71</i> | | 6. AGE (In years last birthday) <i>97</i> YRS | |
| 7a. BIRTHPLACE (State or foreign country) <i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore County,</i> Md | |
| 10. CITY OR TOWN OF DEATH <i>Mount Wilson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Mt. Wilson St. Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>self-employed Store Owner</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD.</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Reisterstown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER <i>609 Main Street.</i> | | 14. FATHER'S NAME First Middle Last <i>Austin Winters</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Captles(?)</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>214-34-3183</i> | | 17. INFORMANT Address <i>Records, Mt. Wilson State Hospital</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary Tuberculosis, far advanced, chronic</i> <i>0112</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>002 / Anticoagulant Heart Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING NO <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/22/1968</i> , to <i>11/30/1968</i> , that (I) (we) last saw the deceased alive on <i>11/30/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>W Newcomer</i> | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) <i>William Newcomer, M.D.</i> | | | | 22e. ADDRESS <i>Mount Wilson, Maryland</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Dec. 3, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Balto., Md.</i> | |
| 24. FUNERAL DIRECTOR <i>H. J. Eckhardt</i> ADDRESS <i>Owings Mills, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>DEC 5 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Alma | | | Edith | | | WOOD | | | Month 11 Day 22 Year 68 11:58 AM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | |
| Female | | | White | | | 11-10-1877 | | | 91 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Missouri | | | U.S.A. | | | | | | Baltimore, Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | St. Joseph Hospital | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Maryland | | | BALTO. | | | Towson | | | 204 E. Joppa Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| LEON | | | ALBERT | | | CLARA GIBBONS HAYDOCK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| No | | | WD-DE-3947 | | | Maurice Wood Fay, Towson Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | | | | | | | | | 3 yrs | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCVD</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year 1968 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1968, to 11/22, 1968, that (I) (we) last saw the deceased alive on 11/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert J. Mahon, M.D. | | | | | | | | | | | |
| 22c. DATE SIGNED 11/22/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D. | | | | | | | | | | | |
| 22e. ADDRESS 204 E. Joppa Rd., Towson, Md. 21204 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | |
| 23b. DATE Nov. 26. 68 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY LORRAINE | | | | | | | | | | | |
| 23d. LOCAT QN (City or Town) (County) (State) BALTIMORE BALTO. MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| WM. Cook - Brooks Towson, Towson, Md | | | | | | | | | | | |
| DATE NOV. 25 1968 | | | | | | | | | | | |



15714

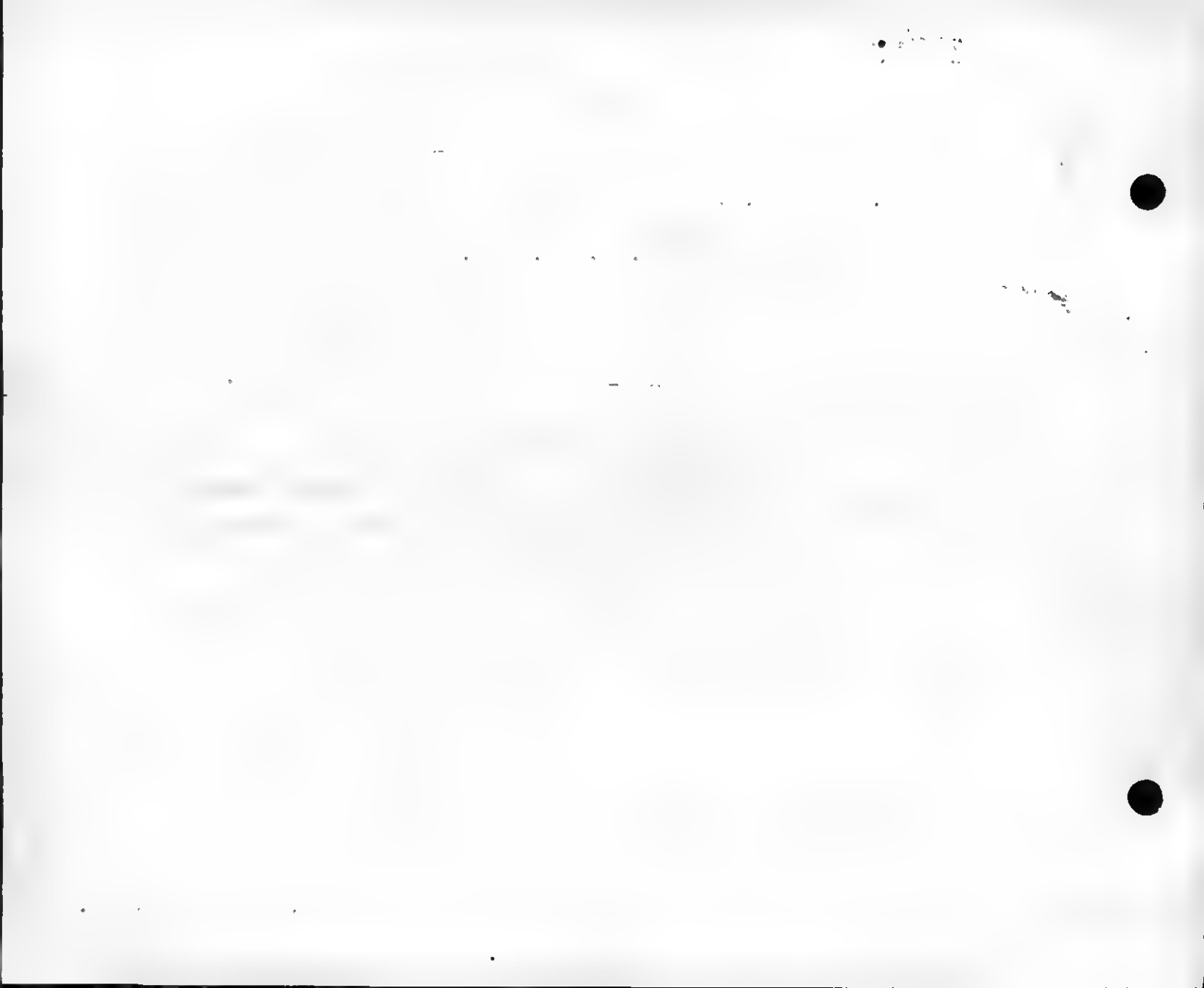
CERTIFICATE OF DEATH

15728

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) Kenneth | | First Aloysius | | Middle Zanzinger Jr | | Lost | | 2a. DATE OF DEATH 11 Month 20 Day 68 Year | | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 1-10-52 | | | | 6. AGE (in years lost birthday) 16 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore County Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 32 Chestnut Hill Lane | | | |
| 14. FATHER'S NAME First Kenneth Middle Zanzinger Sr Last Barbara | | | | 15. MOTHER'S MAIDEN NAME First Mitro Middle Mitro Last Mitro | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO 202-18-7158 | | 17. INFORMANT Kenneth Zanzinger Sr. Address 32 Chestnut Hill Reisterstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse subarachnoid hemorrhage 30 minutes 4309 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Intracerebral hemorrhage - Rt cerebral hemisphere 30 minutes DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of intracerebral vessel (Rt hemisphere) 30 minutes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Samuel Callahan MD | | | | 22c. DATE SIGNED 11/20/68 | | | | 22d. PHYSICIAN'S NAME (Type) H. J. Ellhardt | | 22e. ADDRESS Owings Mills, Md. | | 22f. REC'D BY REGISTRAR NOV 25 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE Nov. 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens, Finksburg, Md. | | | | 23d. LOCATION (City or Town) (County) (State) Finksburg, Md. | | 23e. REGISTRAR'S SIGNATURE James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15715

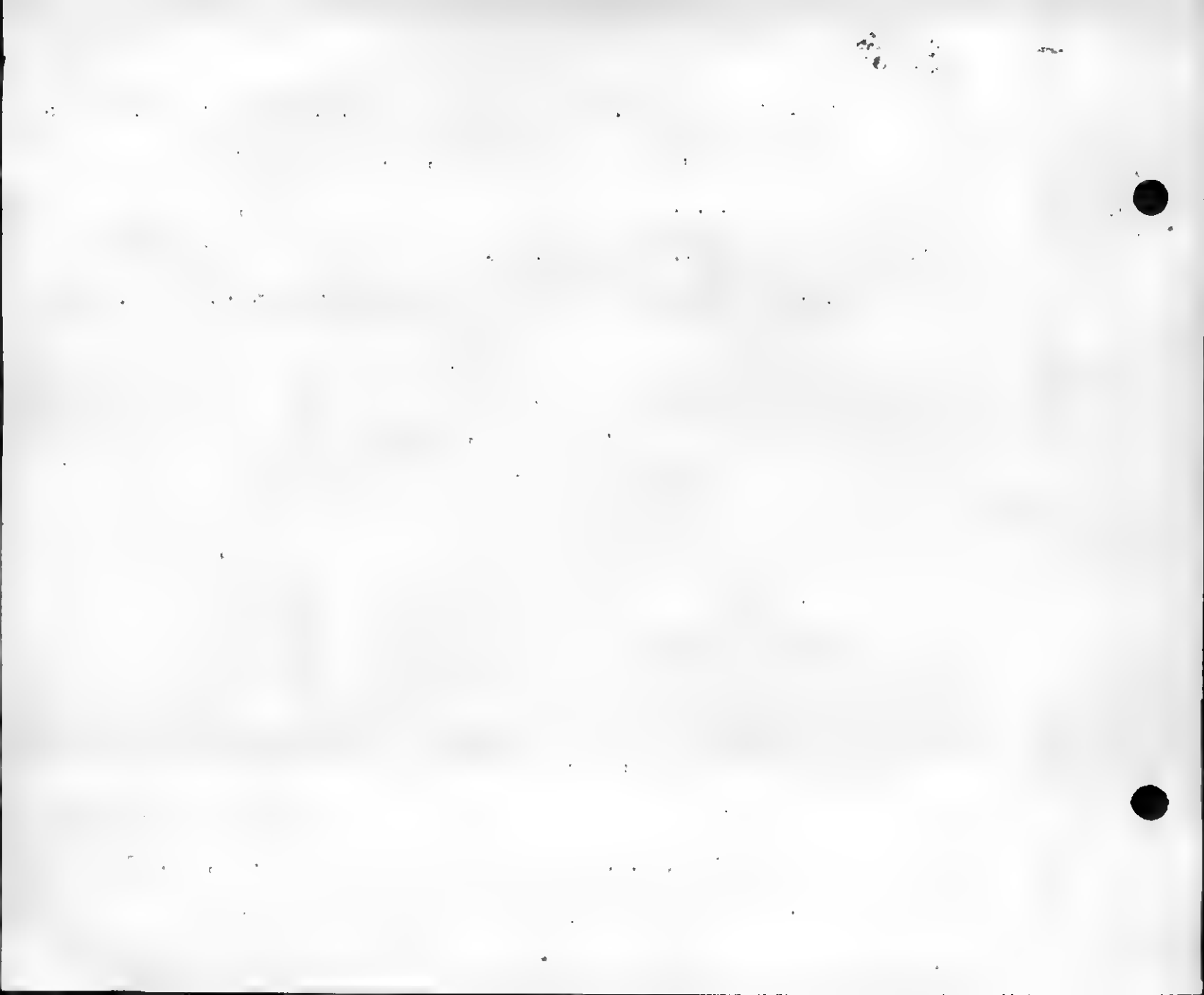
15729

CERTIFICATE OF DEATH

| | | | | | | | | |
|---|------------------------------|---|------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR P M | |
| CHARLES | | F. | | ZELLER | NOVEMBER 3 1968 | | 8:00 P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN |
| MALE | WHITE | JUNE 5, 1905 | | | 63 | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MARYLAND | U.S.A. | | | BALTIMORE | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TOWSON | | ST. JOSEPH HOSPITAL | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| MARYLAND | | BALTIMORE | | | XX | 3017 WOODSIDE AVE. #21234 | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Coronary thrombosis, left descending Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 22, 1968, to November 3, 1968, that (I) (we) last saw the deceased alive on November 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Ines Cilliani, M.D. | | | | DEGREE | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 11-4-68 |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| | | | | 7620 York Road, Towson, Md. 21204 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Nov. 7, '68 | New Cathedral Cemetery | | Baltimore City, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| C. F. EVANS & SON, INC. 8802 Harford Road | | | | NOV 6 1968 | | J. Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Alexander | | | Zinchook | | | Month Day Year November 23, 1968 | | | M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | | White | | March 15, 1894 | | | 74 YRS. | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Russia | | | U. S. A. | | | | | | Baltimore | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Edgemere | | | 3004 Cedarcrest Ave. | | | Trimmer, Bethlehem Steel Co. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | | Dundalk | | | | | | 3916 Glenhurst Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| Not Known | | | Not Known | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Daughter) | | | Address | | | | |
| No | | | 213-07-4145A | | | Mrs. Helen Zaloski, 3004 Cedarcrest Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cancer of prostate</u> | | | | | | | | | | | 2 years | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> | | | | | | | | | | | 2 days | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 177X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | | County State | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased, from <u>11-9</u> , 19 <u>68</u> , to <u>11-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | |
| John V. Conway, M.D. | | | 11/25/68 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| John V. Conway | | | M.D. | | | 914 "D" St. Sparrows Point, Md. | | | 21219 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 11/27/68 | | | Holy Trinity Cemetery | | | Elkridge, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| John J. Duda, 7922 Wise Ave. | | | Dundalk, Md. | | | DATE NOV 29 1968 | | | J Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First PAUL | | Middle W. | | Last ZINKHAN | | 2a. DATE OF DEATH 11 Month 24 Day 68 Year | | 2b. HOUR 4:00 |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH 03-02-1894 | | 6. AGE (In years last birthday) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? Baltimore | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. KIND OF BUSINESS OR INDUSTRY |
| 10. CITY OR TOWN OF DEATH TOWSON, MARYLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CENT. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET AND NUMBER RD-3, Box 180 Phoenix, Md. | | 13c. CITY OR TOWN PHOENIX |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN PHOENIX | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RD-3, Box 180 Phoenix, Md. | | 13f. CITY OR TOWN PHOENIX |
| 14. FATHER'S NAME First John Zinkhan | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME First Margaret Fager | | Middle | | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 220-34-6227 | | 17. INFORMANT J. Wallace Wilson | | Address Phoenix, Maryland | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from Nov. 24, 1968 , to Nov. 24, 1968 , that (I) (we) last saw the deceased alive on Nov. 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE William Pillsbury | | 22c. DATE SIGNED 11-25-68 |
| 22d. PHYSICIAN'S NAME (Type) William Pillsbury | | 22e. ADDRESS Towson Md. | | 22f. ADDRESS Towson Md. | | 22g. ADDRESS Towson Md. | | 22h. ADDRESS Towson Md. | | 22i. ADDRESS Towson Md. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-27-1968 | | 23c. NAME OF CEMETERY OR CREMATORY United Church of Christ | | 23d. LOCATION (City or Town) (County) (State) Jacksonville, Maryland | | 24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. | | 25a. REC'D BY REGISTRAR NOV 27 1968 |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. | | ADDRESS 1050 York Road | | City Towson | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | 25c. ADDRESS 1050 York Road | | 25d. CITY Towson |

W. SIMON

M.

PAUL

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